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LAENNEC.

An Address delivered before the Nu Sigma Nu Fraternity, February 20, 1909.

BY SAMUEL C. CHEW, M. D., LL. D.,

Professor of Medicine in the University of Maryland.

Among the most pleasant recollections of my past professional life is the thought that I was one of the first to extend a cordial greeting and welcome to our friend and colleague, then a newly arrived stranger here, now and for many years past a most cherished member of our own household, in whose honor we are gathered together tonight—Professor William H. Welch. It was at the house of a mutual friend who was also, if I mistake not, a classmate of Dr. Welch at Yale University; and then began a friendship and a regard which have continually grown in my feeling towards him with the lapse of time—a friendship which I shall always account a privilege and a pleasure, a regard which will only increase with increasing years.

I have been asked to respond on this occasion to the sentiment of the name and labors of Laennec, and it is not difficult to find a connecting link between the work of so eminent a pathologist as Professor Welch and that of the founder of the science of auscultatory diagnosis. For it must be kept in mind that accurate diagnosis of affections of the lungs and heart rests perhaps more immediately upon, and is determined by a knowledge of pathological changes in those organs, it is attained with greater precision and greater promptitude with the possession of such knowledge, than is the case with many other, or, perhaps, I may say, any other organic diseases of equal gravity. The special value, indeed, of the method of auscultatory diagnosis is found in the certainty of the conclusions which it reaches in difficult and complicated cases, so that it may be said without exaggeration that it is as powerful a solvent of previously insoluble problems as the calculus is in mathematics.

It seems strange, indeed, that in Laennec's own time one objection urged against auscultation was that it attempted to raise medicine to the rank of an exact science and place it by the side of mathematics and astronomy.

And this also, I think, may be said, that in the entire range of all branches of knowledge there is not a more remarkable instance of profundity of thought, of the power of penetrating to the deep and hidden unknown and bringing it into the light, than is afforded by that science of auscultation which sprang almost perfect and complete—and there is the wonder of it—from the brain of one man, from the brilliant genius of Laennec. And this claim to originality in behalf of Laennec may surely be made without forgetfulness of the fact that in the early dawn of scientific medicine Hippocrates used the sense of hearing in the diagnosis of thoracic disease; nor of the further facts that many centuries later Auenbrugger practiced percussion; and that still later Corvisart made use of this means to some extent. But the method did not in the hands of any of these physicians serve the purpose of establishing certainty of diagnosis. That which Laennec accomplished was the creation of a science which converted previously unheard, unheeded and confused sounds into an articulate language, speaking with logical precision and conveying truth with the certainty of mathematical demonstration. It was said by the eminent pathologist, Rokitansky, that "had Laennec done nothing else for medical science, his discovery of emphysema and of the causes giving rise to it would have been sufficient to render his name immortal." But, important as this contribution to medical knowledge was, it was a small and very limited part of Laennec's great achievements.

Just ninety-four years ago, in February, 1815, Laennec communicated to the *Societe de l'Ecole*

his first results in auscultatory diagnosis. On the 30th of April following he submitted another treatise on the same subject to the same body, and on May 14th—an illustrious day in the history of medicine—he made his first essay with the stethoscope. April and May, 1815—memorable months for far different reasons of a most memorable year. Consider the contrast between the events of the outside world at this time, when the embattled armies of Europe were being marshaled for the tremendous struggle, which in a few weeks found its close in the carnage of Waterloo, and on the other hand the work of the quiet student going on at the same time within the wards of the Beaujon and Necker hospitals, earnest in his labors, constant in his duties, devout, as we are told he was, in his religious faith, strict in his adherence to the Catholic Church of his country, and bent upon the acquisition of knowledge which should lessen human suffering and save multitudes of human lives. And yet, outside of our own profession, how few there are who have known even the name of that great benefactor of humanity.

"Of two such lessons why forget
The nobler and the *better* one?"

Consider the contrast. May it not be likened to the difference between the confusion, turmoil and strife of "the corrupted currents of this world" and those blessed ministrations of good which may engage the serene and beneficent intelligencies beyond the veil?

Throughout the whole civilized world there are few persons who have not at some time, and many of them many times, received the boon of health or the boon of life from knowledge contributed to mankind by the untiring labor, the devotion to duty and the splendid genius of Rene Theodore Laennec.

The work of Laennec placed the pathology and diagnosis of thoracic diseases upon a basis of certainty, and was thus of vast importance in preparing the way for their rational treatment; for scientific therapeutics must always be guided by a knowledge of the nature of disease and the determination of its exact situation and stage.

In discussing the question whether direct inoculation can cause the development of tuberculous disease, Laennec said that on this subject he had but a single fact to adduce, adding that though a single fact may prove little, it ought to be stated. The fact to which he referred was presented in his own case, and it was this, that in examining some tuberculous vertebrae he slightly grazed with the saw the forefinger of his left hand, with the result that a small tumor was by degrees formed in the place containing a yellow body precisely resembling a crude tubercule.

This infection may have caused the pulmonary tuberculosis of which he ultimately died, a victim, it may be, of his earnest quest of knowledge and a victim, too, of that malady upon the nature of which he had himself shed such abundant light.

REPORT OF A CASE OF INTESTINAL OBSTRUCTION COMPLICATING ACUTE APPENDICITIS.

By C. F. Strosnider, '09,
Senior Medical Student.

Name, Robt. Washington; race, black; age, 20 years; civil status, single; occupation, laborer; date entered, August 10, 1908; date discharged, September 5, 1908.

Diagnosis.—Intestinal obstruction complicating acute appendicitis (high post coecal).

Complaint.—Constipation and pains in abdomen; family history, father and mother living and well; no brothers or sisters in family. Family history negative as to tuberculosis, rheumatism, gout, haemophilia and insanity.

Past History.—Born naturally; was healthy as a child, having during childhood whooping-cough, measles and chicken pox, but negative as to sequelae. Teething normal; walked at age of one year; always healthy until present illness.

Habits.—Smokes moderately, eats heartily and fairly regularly. Does not chew tobacco. Drinks beer or gin occasionally. Drinks three cups of coffee daily. Keeps late hours at night.

History of Present Illness.—Was taken sick on August 10, 1908 (Wednesday), about 2.30 P. M., whilst driving a cart, with nausea, vomiting, severe abdominal pains, which were general, accompanied by a diarrhoea, the stools being greenish in color and at first copious in amount.

Each attack was accompanied with severe headache. Such attacks lasted for about fifteen minutes, gradually subsiding, until the pain and other symptoms would be gone for a

period of about fifteen minutes. About six o'clock his bowel movements did not accompany the attacks, and pain began to radiate over the right side of the chest from the region of the gall bladder to a point under the right scapula and shoulder; also with shooting pains radiating down the back and terminating in the glans penis.

A physician was called in and diagnosed the case as one of "cramp colic," and treated the same as such. Pain was relieved, but he continued to be nauseated and constipated. On Saturday evening his pains returned and the abdomen began to become distended, which gradually grew worse until Sunday morning, August 14, when he was sent to the hospital. Upon arrival he was found to be suffering with excruciating pain, and was very restless, the abdomen being greatly swollen and of boardlike hardness. He had been able to retain but very little food since the attack began. His temperature registered 104° F., pulse 140, respiration 40.

Physical examination developed the following:

General Condition.—The patient lay on his back, with rather difficult breathing, being restless and anxious. Was well nourished, weighing 150 pounds.

Skin.—Black, tight, with plenty of sub-cutaneous fat; no eruptions; rather hot and moist; heavy suit of hair; nails rather blue.

Digestion.—Teeth in excellent condition, mucous membrane and lips of mouth appeared dry and rather congested; tongue was covered with thick white coat and protruded without tremor; swallowed normally; no tracheal tug; stomach was unable to retain food on account of nausea and vomiting, which vomit contained bile.

Abdomen.—Muscles were boardlike in rigidity; no abdominal movement was perceptible during respiration, as the muscles were fixed.

Tenderness.—Maximum point was on right side from gall bladder area to McBurney's point. No enlargement of the gall bladder or appendical abscess could be made out by palpation, but dulness could be elicited by percussion on the right side to the right of the rectus muscle; otherwise the belly was tympanitic.

Vascular System.—The heart sounds, its size and position were normal. Pulse rate 140 per minute, regular in force and rhythm, good volume and compressible, high tension.

Respiration. — Breathing rapid (40 per minute), rather shallow and expiration prolonged, owing to abdominal muscle fixation.

Nervous System.—Had anxious expression, severe headache and appearance of suffering great pain; very restless, thirsty and begging for relief; special senses were negative; could not test motor areas for faulty gait or diseased joints on account of condition; tactile, pain, heat and cold and muscular senses were normal; reflexes normal; generative organs appeared to be normal.

Microscopically.—Sputum was negative.

Blood.—Leucocyte count was 12,000 per C. M.; haemoglobin 80 per cent.

Tertian malaria parasites were present in small numbers.

Urine.—Catheterized specimen of 500 c. c.; acid in reaction, sp. gr. 1032; slight ring of albumen in Heller's test; sugar negative; Indican was present in excess.

Cells.—Few kidney cells and bladder cells present; few hyaline casts and a small amount of mucus. Highly colored by indican.

I completed history at 12.30 P. M. and gave the above mentioned diagnosis. Patient was taken to operating room at 1 P. M.

Operation—Anaesthetic Ether.—Anaesthetist, Dr. J. D. Kerr; surgeon, Dr. R. B. Seem; assistant, the writer. Duration of operation, one hour.

A vertical incision was made four inches in length along the outer margin of the right rectus muscle, the fascia muscle being pushed in towards the mid line, the posterior fascia and peritoneum were picked up, respectively, and cut, the latter being caught by forceps and incision completed. Superficial skin and fascia vessels were clamped and tied and deep abdominal retractors put in desired location and traction made. On inspection the omentum was found to be tied down to the caecum and ascending colon, and the small intestines were greatly distended with gas. Upon walling off the intestines with a Boston pack the omentum was released at the highest point, and a pocket of pus was discovered, which extended from the base of the appendix to under the right margin of liver; about one pint of pus was mopped from this pocket. Appendix was four

and one-half inches long, being located postcaecally (high) and tied down by adhesions, and ruptured and gangrenous at the distal three inches. Adhesions were broken up and appendix freed with great difficulty. It was clamped, tied off, a pucker string put around the stump, carbolic acid and alcohol used on stump, which was turned into caecum, when the drawstring was tied and a row of sutures put over the same, drawing peritoneum together over it. The omentum was found to be thrombosed to the extent of about 2½3 inches, which was tied off and amputated.

Intestinal Obstruction.—At a point three inches from the ileocaecal valve a small band about the size of a shoe lace was found to constrict the ileum, causing absolute obstruction of the intestine. This band did not encircle the intestine entirely, but extended across it from side to side. No cause could be given for its presence. It was tied off with fine silk and clipped with scissors, thus removing the obstruction. No other cause of obstruction could be located by a further examination of the intestinal tract, and drainage was provided for by placing a long cigarette drain in the pelvic cavity, another under the liver and a third one at the base of the appendix.

The incision was then closed between the upper and lower drains, the peritoneum, fascias and skin, respectively, with interrupted sutures of catgut (20-day chromized); wound was dressed with gauze, cotton and bandage.

Patient was returned to ward in a shocked condition. Temperature, 103½; pulse, 150; respiration, 36. Pulse was weak and small in volume and irregular in force and rhythm; extremities were cold and clammy. Patient's stomach was washed out with warm water. Hot blankets and water bottles were applied to the extremities and the foot of the bed elevated until the shock had been overcome.

Hypodermodysis of 800 c. c. normal salt solution was given in the axilla; hypodermics of strychnine and hot brandy at four-hour intervals. After recovery from the shock the patient was put in a sitting position.

After Treatment.—No food was given, and only cracked ice by mouth for first 24 hours. Nutriment enemata of peptonized milk and warm coffee (with whiskey, zss) q. s. ziv., t. i. d. Then albumen water zii q. 2 hrs., and on third or fourth day milk z iv. q. four hours. On seventh day soft-boiled eggs, milk and toast, soups; on twelfth day regular house diet.

Drugs.—Strychnine, gr. 1-30 q. 6 hours, alternating with nitroglycerine, gr. 1-100, quinine sol. gr. ii ss, q. 3 hours. Nitroglycerine was dropped on sixth day. Patient's pulse, respiration and temperature rapidly improved until normal was reached. Each nutriment enema was preceded by a normal salt enema.

Hypodermodysis of 800 c. c. normal salt solution was given daily for three days, which seemed to do great good.

Dressing.—Wound was dressed daily for eight days, then every other day until he was discharged. On third day deep pelvic drain was removed; on fifth day drain under liver was removed (discharge having ceased from these drains); on sixth day drain over stump of appendix was removed and shortened, again on eighth day, and entirely removed on twelfth day, and iodoform gauze used in its stead. At each dressing area around wound was thoroughly cleansed with a 1-3000 bichloride sol. and the wound with a saturated solution of boracic acid.

The patient was kept in a sitting posture until the eighth day, then gradually lowered until twelfth day. When discharged the wound was healed and no parasites could be found in his blood.

This case was diagnosed and after treatment given by me while in charge of colored wards as substitute interne, Wilmington, N. C., City Hospital, from June to September, inclusive, 1908.

CORRESPONDENCE.

SOME EXPERIENCES IN THE VALLEY OF THE AMAZON.

(Concluded from February Number)

This is the first night on shore for over a month; although we were at Para for two days, sundown was the signal for a quick get-away to the Ravelston, and the anti-mosquito cottage on board. Dr. Lovelace was one of the pale-faced persons who came down to see our boat tie up to the bank. He appears to be a good one, and will take charge of the hospital in a few days. Porto Velho is a very queer place. A space of about ten square acres has been cleared and a general

store, the commissary and buildings for the engineers have been erected. A wall of dense vegetation surrounds this clearing. You will see by the photograph that they are not little fellows. They are giants. The smallest is at least 8 feet in diameter 100 feet above the ground. Its lowest branches would just about escape the top of the Washington Monument, if placed alongside of Baltimore's patriotic effort.

Supper was not bad, and these aenemic engineers are at least optimistic.

Next to the pickle jar was a large bottle of quinine. Nearly every man took 10 grains. Some took more, and all wanted to know the latest news from the States. Two of the men had only left the table for a few moments when they separated themselves from their supper. Poor fellows! It's "Algide" with them, I think.

I left Porto Velho today in a launch for San Antonia, where tonight will be spent. An American Indian, who was in the army in the Philippines, is with me to act as interpreter and servant. At daybreak a canoe with native rowers is to meet me just above the Falls and paddle me up stream for two days to San Carlos.

* * * * *

This wonderful trip will never be forgotten. The canoe kept close to the shore at times, and it was almost like rowing through a great conservatory. The river is high and the trees and vines trail in the water. Alligators are almost everywhere, and parrots and monkeys constantly remind you of their presence with their shrill cries. Often the rowers had to get out of the boat and draw it with a long rope past some particularly rapid place in the river. When the canoe reached Tietonia the canoe was tied up below the Falls and the cargo was unloaded and carried above the Falls to a small warehouse, preparatory to being placed on another canoe which is waiting to go up the river at daybreak. * * I was most fortunate last night, and instead of sleeping in a hammock, spent a pleasant evening and had a good dinner at the house of a Spaniard who is agent for a wealthy firm of rubber exporters.

The Falls are not particularly high, but the volume is probably three times as great as that of Niagara, and the roar is deeper and stronger.

BOATS LOADING TO GO UP THE MADIERA RIVER ABOVE SAN ANTONIO

I stood there in the gray dawn and watched these native rubber bearers who were carrying the rubber around the Falls to be put in the canoe below, shuffle along. Each had a great ball of rubber on his head. Outside of the roar of the falling waters there was not a sound, and Dore must have seen some such weird place. His pictures would lead you to believe that he had. After what I have seen today I really don't care very much if I do get sick up country. San Carlos was reached in good time. San Carlos is on the map and printed in letters large enough to give the impression of a village, at least. San Carlos consists of a thatched three-room hut and a long shed for the 16 pack mules. I have seen this deceptive way of marking even cross-road stations in Iceland and Norway also. I found here a Mr. T., who is bad with the fever. He was carried down yesterday in a hammock by eight natives. Quinine will fix him right, I think. The storehouse keeper is out of his head and raving away at a great rate. It may be just fever, but I think he has poisoned himself with too much quinine.

Tomorrow the start will be made for the interior, since the mule train has arrived. The mule team master is lame with a big ulcer on his leg. A tropical ulcer, no doubt, and he refuses to let me clean and dress it.

Bags, scope and outfit were packed on mules and a seven-hour ride over a rough trail brought me to the front. You can't describe such a ride as this. So dense is the vegetation that the sun's rays reach the earth only as long pencils of light. Wonderfully brilliant butterflies flutter about in the cleared trail, and when they chance to cross a slanting sunbeam for an instant they flash into view like an explosion of burning color.

It is hard to imagine the effect they produce as their wings flash and close and flash again in the sunlight. In places the trail is carpeted with fallen blossoms inches deep. Pale pink, deep blue, lavender, orange, almost every color of the rainbow. We marvel at the beauties of some of our great conservatories, but in comparison with this wonderland they sink to the level almost of the toy gardens some diligent fathers build under the Xmas trees for their own as well as their childen's delight. Monkeys, small and large, scamper along and peer down at you. Twice during the day I saw enormous spiders. One killed by an engineer measured eleven and three-quarter inches from one front to the opposite hind leg. Hard to believe, I know, but a twenty-five foot four inch snake was killed by our preliminary party. Bichloride was all I had to prevent its skin from rotting, and a severe illness from bringing it back to the States with me.

The camp was reached before dark and a cordial welcome awaited my guide and myself. Of the 14 white men in camp three were quite sick and several others about as an anaemic a looking lot as I ever saw. Of the 40 odd laborers I learned later 75 per cent. had been sick during June. * * *

We are now in a part of the world unknown before to white men. Parrot soup and fried monkey were served at my first meal. Monkey meat is very tough. But the photograph of the camp will show you how wild this country is. Wild pigs are good to eat, but hard to shoot, and so parboiled parrots and rice soup made from them is at times acceptable, and, except for the toughness of it, monkey meat is not at all bad.

The 2,000-mile journey up stream is over and our ship is already tied to the banks at Porto Velo, near San Antonio. We should have landed an hour ago, but there was some trouble with the custom officers. Every boat that comes up the Amazon must bring along two pilots and two custom officers from Para. The pilots draw enormous salaries and are very big people. And they are grafters of the first water. It is reported that when we left Serpa it was necessary for Mr. M. to hand out 6 Cantos before the freight steamer could have a clean bill. A Canto is one thousand milres, or about $320. And all this after the duties had been properly attended to at Para before leaving there.

Either most of the people are far from well or there is a tropical look which one may get used to later. We are not yet landed, but all of the people from the camp near the top of the bank have come down close to the boat. They look far from strong and walk as though they were just out of bed, convalescing from a typhoid fever attack.

Here at Porto Velo I am making hasty but complete preparation to go up the river, where I will join the preliminary exploration party which has penerated into a part of the jungle never before seen by white men.

It seems almost impossible for me to get along

to Beri-Beri, tropical ulcers, dysentery, and, most of all, malaria.

It must be borne in mind that the people of this region come from many parts of the world. They are contract laborers, brought from the Isthmus, Spain, Portugal and from the coast. They are brought to work on the new railway. They get sick, and mostly they are sent home as per contract. They don't last long. Latent diseases develop shortly after arrival at headquarters. Subtertian malaria, shown by blood examination of many new arrivals, required less than a month to spring into life after locating in the fever zone. Every one of them, and the engineers also, get the fever without exception. Everything is grafted on malaria. The anapholes leads the German, Anklastoma and Ascaris Lumbracoides bring up the rear. Tropical ulcers are present in many cases and are often bilateral.

One of the most interesting diseases observed was tick fever. I was fortunate in having two cases to study in a period of nearly two months, and I will give the history of one case later. Why more cases did not develop is odd, for each night it was necessary to search carefully and remove the day's crop. It was a continual case of sweat bees, stinging flies and piums. There are surely chances for infection not yet known. Later many of the undifferentiated fevers will be better understood and their etiology is only a matter of time. Very truly,

ALBERT H. CARROLL, M. D.

McDOWELL HALL, HISTORIC MAIN BUILDING AT ST. JOHN'S COLLEGE, DEPARTMENT OF ARTS AND SCIENCES, DESTROYED BY FIRE.

McDowell Hall, named after John McDowell, LL. D., first president of St. John's, the main building at St. John's College, Annapolis, was destroyed by fire February 20, 1909.

The fire started in the upper part of the structure and rapidly spread to the cupola. Practically all of the furnishings of any value were saved, including the equipment of the fraternity rooms, college records and the large and valued collection of class shields that adorned the balconies of the chapel hall.

The destruction of the building is practically complete, a section of the east wall some seven feet deep having tumbled down, and it is thought probable that other parts of the wall have been weakened to such an extent that they will fall. The falling of the wall caused much regret among the college authorities, as the plan of rehabilitating the structure with the use of the original walls had been discussed, and much of the historical interest of the building, therefore, would have been restored.

The loss to the structure and contents of over $40,000 is covered partially by insurance of $25,000.

McDowell Hall, the oldest building of the college group, is one of the most interesting of the historic buildings of Annapolis. It was begun in 1744 by Governor Thomas Bladen, but the legislature of the colonies decided that he had exceeded his power in appropriating the money for the erection of the building and ordered the work stopped.

It remained partly completed until 1784, when the building and ground upon which it stood was transferred to King William School, which then became St. John's College, and the money for its completion was appropriated by the state.

Since that time it has been used as the main building of the college group. In 1886 the cupola was set on fire by a bolt of lightning, but the fire was extinguished without serious damage being done.

In front of the building stands the "liberty tree," a tulip, under which it is said a treaty with the Indians was made.

The friends of liberty also held meetings under the tree in the days just before the Revolution. The tree is supposed to be older than Annapolis.

Unanimously moved by the determination that a more ample McDowell Hall should rise from the ruins of the old one, and that the new structure should be built upon the lines of the old, and be included as far as possible within its historic walls, the movement for the reconstruction was launched at an enthusiastic meeting of the alumni and influential friends, which was held in the college library February 25, 1909. The meeting went into the consideration of the resolutions which were to be presented to the board of visitors. The resolutions suggested that architects be employed to test the possibility of retaining the old walls and to de-

vise plans for the rebuilding, with such wings and additions as would not destroy the old plan or disassociate it with its historic traditions. The cost of the new building was placed at approximately $100,000. The resolutions further urged that a committee be appointed at once to lay the claim of the institution before the public, and particularly before men and women of wealth and philanthropic disposition and before the custodians of public educational funds.

After the passage of this resolution another resolution, offered by Judge Henry D. Harlan, of Baltimore, a graduate of the college, providing for the appointment of an alumni committee on the rebuilding of McDowell Hall, was carried. The committee will be appointed later.

At the conclusion of the formal business Mr. Poe presented the resolutions of regret and sympathy of the Regents of the University of Maryland, of which St. John's is the academic department.

DO IT NOW.

According to an editorial in the February issue of THE HOSPITAL BULLETIN, the long-cherished dreams of a president of the University of Maryland appears to be a possibility of the not distant future. Announcement of the creation of this office and its first incumbent may be announced at any moment by the Board of Regents, who have at last come to recognize the disadvantage under which our institution labors before the public, alumni, benefactors and sister institutions. That the Board of Regents has appointed a committee from its number to investigate and report the ways and means of providing a president, is indeed welcome news to all loyal alumni. For some time alumni have been agitating the creation of this office, and the appointment of this committee was the result. The Regents are to be congratulated upon this move, which should forever hush the accusations that the institution is being run solely in the interest of the members of the several faculties.

Now it is up to the alumni to aid and abet the Regents in every way possible to consummate such a desirable, yea necessary, change. Let's cease petty carpings and whoop it up. Let's present a solid front and show devotion and loyalty by providing at least a partial endowment towards a presidency. In no other way could the alumni more materially manifest an earnest in this movement. Every alumnus should be not only willing, but glad to aid in the procurement of a president. If the alumni have ever felt a tinge of love for the University, any pride in its past glories, any hope of future greatness, this is the time of times to express it in a material way. If one ever contemplate doing anything for Alma Mater, do it now, for ye knoweth not what tomorrow bringeth forth.

Another matter which shows the Regents alive to the need of the times is the cordial reception given a petition from the General Alumni Association imploring the creation of a Board of Alumni Counsellors. This has likewise been referred to a special committee for mature and deliberate consideration. To be candid, the Regents recognize the defective organization under which they are laboring, and if proper support and encouragement is extended to them, this no doubt will be changed. Indeed, there is talk of petitioning the next Legislature for a new charter. The burden of managing such extensive property interests has become too onerous to the professors, who are more than willing to transfer this trust to other shoulders, provided the change will not bring chaos. It is no more than just that our alumni meet this spirit of sacrifice with as much sacrifice upon their part. Here is your long-sought-for opportunity to aid in the uplift of our dearly beloved University. See that you make the best use of your opportunities. Deny yourself something to render her a service, not necessarily pecuniary; attendance of the meetings of the General Alumni Association, a body organized for the creation of the "University Idea," a fosterer of all which is good for the University, a body which has from its inception worked constantly against almost insurmountable barriers for the placing of the University upon a sound basis, a body which has the temerity to petition the Regents for a general Centennial Celebration and a paid head for the institution, but also for a Board of Alumni Counsellors, is a most valuable service. Show your interest in our institution by your presence; you have been clamoring for recognition; show your loyalty and sincerity by attending the meetings of the General Alumni Association, where these momentous questions are under consideration and deliberation.

ALUMNUS.

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EDITORIAL.

BEGINNING OF VOLUME V.—With the present issue THE BULLETIN begins its fifth year of publication. In looking back over the four years past the Editor and Business Manager of THE BULLETIN have cause both for satisfaction and for regret. It is some satisfaction to have kept the regular monthly issues before its many readers when the difficulties of the task and the many embarrassments which are associated with the publication are taken into consideration. It is a source of regret to know that THE BULLETIN has not reached the high standard which is to be desired.

When it is borne in mind that THE BULLETIN is a class organ dependent upon a single class of readers and subscribers, it can be readily understood how difficult it has been to obtain matter for its reading columns and money to meet its business obligations. That THE BULLETIN could be made a much better publication than it is the editor is painfully aware. If he has not done the best he could, he has done the best that it was possible for him to do under existing circumstances. The editor has many and pressing duties calling for his time and energies apart from the work he has given to THE BULLETIN. He has only worked for THE BULLETIN from force of necessity, because up to the present time he has not been able to impose this work on another's shoulders. His desire to see the publication live and do a service to Alma Mater and to her Alumni has been the only motive which could have held him to the job for four years.

The time is near at hand when some younger and more capable man connected with the Medical Department of the University should take up the entire management of THE BULLETIN and relieve its present tired-out representative. It is earnestly hoped this individual will be found at no remote date. THE BULLETIN needs not only a more energetic and progressive editorial management, but it most urgently needs a more capable business head. In this age brains and money are essential to progress. The man who has the brains to do good work and the money to aid in the development of an enterprise is the man who will get results. THE BULLETIN looks for no marked progress in its work until this man is found.

Recognizing the shortcomings of the present management of THE BULLETIN, it is but fair to state that the alumni and friends of the University owe something to the publication which has tried to serve them for four years. If a more liberal financial and literary support was given THE BULLETIN would soon be able to reflect this support in its reading matter. When an editor is forced to beg for material and to dun his readers for money his amiability is sorely taxed and his work is unsatisfactory.

THE FIRE AT ST. JOHN'S COLLEGE.—The Alumni of the University of Maryland will learn with deep regret of the recent destruction by fire of the venerable McDowell Hall, at St. John's College. This old building possessed not only a practical value, but an historic interest. Its loss is one which cannot be restored in full.

Since St. John's College has become by affiliation the Department of Arts and Sciences of the University a strong bond of union has grown up between the different departments, and the ties of interest and friendship have been greatly strengthened. Any misfortune coming to any one department will be keenly felt by all departments of the University. Hence the sympathies of all of the Alumni will go out to St. John's in her recent loss. It is an ill wind which blows no good. THE BULLETIN believes that the loss sustained by St. John's will in the end work greatly to her advantage—that she will arise from her ashes with renewed vigor and purpose, and with a modern equipment for her educational work. The growth of St. John's during recent years has been marked for thorough and progressive methods. Not only has she grown in number of students and in the high character of her teaching body, but she has improved her courses of instruction to

meet the standards of the leading colleges of this country.

The military and educational training she gives her students will, we believe, measure up to that given by any college of like character in America. The location of St. John's at Annapolis, the capital of the state, is exceptionally fortunate. The social life and healthy environment of Annapolis give a valuable stimulus to student life in that community. With the Naval Academy and St. John's College Annapolis has become an educational center of wide distinction. The association of large student bodies and large corps of teachers with the refined society of the capital of the state is highly beneficial to all classes.

THE BULLETIN indulges the hope that the burning of McDowell Hall will call attention to the claims of St. John's College upon the people of Maryland, and that our legislature will deal generously with this venerable school, which has so long served the youth of our state.

ST. JOHN'S LOSS.

There is more than the usual loss in the burning of any of the old buildings at Annapolis. One around which history clustered with special interest was McDowell Hall, and its destruction on Saturday was a great misfortune.

Friends may and should rush to give to St. John's a main building that will take its place and have many comforts and facilities which McDowell did not possess, but nothing can possess that peculiar value which comes from the long association of many distinguished names.

In this connection it is worth while to remember that St. John's College has done great work for Maryland, and that it ought to have a larger support from the people of the state. The rebuilding of McDowell Hall might very appropriately be the beginning of a new era in the life of the college. It presents a fine opportunity for its well-to-do and public spirited alumni.—*Editorial, Star.*

HOSPITAL SHIP FOR THE POOR—HARBOR ENGINEER LACKEY INDORSES MR. HELLER'S PLAN.

City Councilman Heller has introduced in the City Council a resolution providing for the appointment of a commission to report on plans for the establishment by the city of a hospital ship in summer for the poor. Harbor Engineer Lackey is in accord with the suggestion, and has promised to co-operate in the project.

The vessel would be used by poor sick people and would make daily trips on the bay. Efforts would be made to have it accommodate 1,000. Mr. Lackey said such a boat could be built for $30,000 and has suggested that churches, lodges and business and improvement associations may be gotten interested in it, and the ship be built by popular subscription and maintained by the city.

A MOCK TRIAL.

Under the Direction of Joseph T. Smith, M. D., Department of Medicine; Mr. Eli Frank, Department of Law.

REPORTED BY J. T. S.

On the evenings of February 12th and 13th a mock trial was held in Davidge Hall in which students from the Medical and Law Departments took part. The synopsis of the case was as follows:

On the morning of December 10th William Gillis died, and James Atchison, his nephew, is charged with causing his death by the administration of tartar emetic. The circumstances are as follows:

William had been sick for a week, complaining of headache, nausea and weakness. He was a man of sixty years of age and always enjoyed good health. At times, however, he would indulge in drink, but had not for some weeks before his last sickness. His physician in attendance could find no special cause for the trouble, and as, under treatment to allay the symptoms, his patient improved, he was satisfied.

On the morning of December 9th William did not seem so well—had more headache and vomited for the first time. The physician saw him twice that day, and, although his patient had vomited several times, he was not able to see the vomited matters, as they were thrown out before his arrival. At midnight the doctor was hastily summoned, as the messenger said his patient was much worse. Upon arrival he found his patient delirious, and soon after convulsions set in. These were relieved by the administration of chloroform, but recurred when the influence of the drug wore off. After

working with him until 7 A. M., the man broke out into a cold perspiration, collapse set in, and the man died at 8 A. M.

The vomited matters, having been thrown out, could not be had for examination. The physician, from the condition of his patient, suspected poison, and in looking about found a tumbler in a cupboard in the bottom of which was a small quantity of a white sediment. This, upon analysis, proved to be tartar emetic. His nephew, who was his constant attendant and the heir to his fortune, was accused of administering small amounts of tartar emetic, and, not getting the results he desired, finally gave him a larger dose. The sediment in the glass he alleged was left over from some he had used in making a poison paste for rats. While no tartar emetic was found in the stomach, it was contended that its absence proved nothing, as it might have all been thrown up at the time of the vomitings. The mucus membranes showed congestions, as did the stomach, but as it was known that the man had taken powders to control his drink habit, and as it was known that these contained antimony, the defense alleged that the man had been taking some of the powders before he was taken sick. It was proved that he had taken none of them during his sickness, and that the congestions were due to the tartar emetic in said powders.

The court proceedings were carried on with all the detail and dignity of a real court of justice, those present rising and standing until the judge took his seat, the crier calling the court to order, the calling of the roll of the jurors, clerk, reporter, counsel and witnesses, both ordinary and expert. The court was constituted as follows:

Judge—Eli Frank.
Clerk—G. C. Feurst.
Crier—
Geo. McG. Benson.
Bailiff—Benj. Beck.
State's Attorney—
R. Legare Webb.
Assist. State's Attorney,
Samuel J. Fisher.
Counsel for Defense—
Frank B. Evans and
A. H. Siskend.
Sheriff—W. Linn.
Prisoner—Mr. Ebert.

Witnesses for the Prosecution:

Family Physician—
Charles Schmidt.
Chemist—
H. W. Coddington.
Butler—
Raymond C. Reik.
Post-Mortem. Physician,
Jose Igartua.
Druggist Relief Clerk—
Jas. G. Edelen.

Witnesses for Defense:

Chemist—
R. C. Howard.
Medical Expert—
J. Ostro.
Prisoner—Mr. Ebert.
Medical Expert—
I. M. Macks.
Chemist—Mr. Alfeld.
Druggist—
E. E. Nichols.

Jurymen:

R. E. Jones, Foreman;
E. H. Wooten,
E. E. Hearn,
Arthur Trader,
W. H. Chambers,
S. E. Mueller,
David Ford,
Mr. Wolf,
J. J. Greengrass,
Mr. Mullen,
Mr. Hubbard,
Mr. Backrack.

The attendance of the students was excellent, and all seemed greatly interested in the proceedings, which were instructive, with just enough variety, and at times amusement, to prevent monotony. The judge presided with dignity, and was called upon on several occasions for his decision, owing to the disagreements of counsel. The disagreements of counsel, the objections of one side to the questions of the other, and the discussions arising therefrom, gave all present a good insight into the way lawyers watch the interests of their clients. The excellent examinations, cross-examinations and re-examinations presented the manner of securing evidence in a most favorable light. Much amusement was occasioned when, upon cross-examination, a witness was asked to state the difference between antimony and alimony. Upon the question being objected to, counsel said he was trying to test the general knowledge of the witness. The judge allowed the witness to answer. An old man (the chum) came in with a cane and books under his arm, and well represented the garrulous witness. The medical experts, the chemical experts, the butler and the family physician did themselves great credit as witnesses, and presented such a variety as to make that portion of the trial intensely interesting and instructive. The introduction of a glass having a sediment and of the record of the druggist with an erasure added to the interest. The age of some of the witnesses, the possession of an automobile by one, the length of time another had been in practice and the prize obtained by a third for a paper on tartar emetic afforded much amusement. The speeches of counsel at the close were listened to with interest, the arraigning of the opposition witnesses by one,

the fervid eloquence of another and the careful presentation of the testimony of the witnesses by a third made a pleasing and interesting variety, and exhibited in a most engaging manner the diverse ways in which the jury receive the important points in regard to a case and have presented to them the matters testified of by the witnesses.

All present were gratified by the ability displayed by the students, for it was left entirely to them to work out and present the case.

This is the first attempt of the kind that has been made, and it was successful in giving the students a clear insight into court proceedings and of bringing about a more intimate relationship between the Medical and Law Departments, a relationship which, if it were assiduously cultivated, would do much towards promoting a more sympathetic feeling between these great professions when the students go out as active physicians and lawyers.

ITEMS.

THE CANDIDATE'S PRAYER.

Dr. R. C. Buck, of the class of 1874, now practicing his profession with success and distinction at Garrisonville, Va., writes to the editor of THE BULLETIN that the following verses were removed by him from the Bulletin Board in the hall of the University, and have been kept by him as a souvenir for the past 35 years. The author, he thinks, was Dr. Norris, of his class, long since dead:

My carpus and each phalanx is
Jagg'd, numb and worn and cramped;
My poor encephalon o'ertaxed,
My energies all damped.

My conjunctivae are suffused,
With films my iris hooded;
My Dura Mater's sinuses
With too much blood are flooded.

And O, my nervous system is
All shattered and o'erstrung;
The constant studying because
The "physic-books" among.

My stomach does but ill secrete
Its proper juice, the gastric,
Depending on derangement of
The Eighth—the pneumogastric.

And my own cutis, I know 't well,
Is of a sickly sallow
(Although I've taken Calomel),
It's stained a bilious yellow.

My ills, God save the mark! are great,
And my afflictions legion;
At times I feel a deadly weight
In my precordial region.

And Phthisis Pulmonalis, too,
Makes to me its migration;
For I've been told that I, alas!
Had bronchial respiration.

But it's no marvel that I'm sick;
Six lectures, sometimes seven,
Each day, and then the "Quiz" to boot
Five times per week, good Heaven!

And then withal the deadly fear
Of being "pitched" when I
Within the "Green-Room" shall be asked
The wherefore? and the why?

Therefore incline Thy bounteous Ear,
Thou Lord divinely great,
And O, fulfil the earnest pray'r
Of me, A Candidate:

"Make our Professors' breasts to feel
Some kindliness when they
Examine us poor fellows on
A not far-distant day.

"Make that they may recall the time
When they were students yet;
Their own sad fears and doubts, good Lord!
Let them not then forget!

"Make them recall that we were forced
To "cram"—and hence forgot
The details, the minutiae,
Though maybe gross things not.

"Let them remember that it took
Them years of study to
Learn all they know—and let them look
On us with friendly view!"

THE VILLAGE DOCTOR.

A Parody on the Village Blacksmith.

By the Editor.

Seated in his one-horse chaise,
The village Doctor makes his rounds;
The Doctor, a grand old man is he,
Whose weight is scant two hundred pounds;
But when the call for help is made,
The Doctor at his post is found.

His hair is white, thin and long,
His face is full of cheer;
His brow is knit with anxious thought,
He knows no sense of fear;
He stares disease full in the face,
For life to him is dear.

Day in, day out, from year to year,
You see him come and go;
You see him on some mission bent,
You hear his old horse blow;
He stops not for Summer's sun,
Nor Winter's blasts of snow.

The children coming home from school
Greet him passing by;
They love to cheer the grand old man,
Perched in his old chaise high;
As they catch his kindly greetings
They seem to hear him sigh.

On Sundays when he goes to church,
He sits quite near the door;
He hears the parson pray and preach,
He thinks about the poor,
Needing, perhaps, his services,
And it makes him sorrow more.

He recalls the sick and suffering,
How on beds of pain they lie;
He needs must give relief to some,
But some are sure to die;
His big heart fills with emotion
As tears drop from his eye.

Sorrowing, toiling, comforting,
Onward through life he goes;
Each morning finds him at his task,
Which evening does not close;
Someone helped, others calling,
But night brings no repose.

Thanks, thanks to thee, our dear old friend,
For the good which thou hast done!
For all thy deeds of kindness,
For all the victories won;
May angel voices praise thee
Where angel songs are sung.

The Nineteenth and Sixth Annual Meeting of the General Alumni Association was held in the Law Building of the University of Maryland, Tuesday, February 23, 1909, at 8.30 o'clock P. M.

Very important business was discussed and several resolutions of great moment to the University were introduced. The first order of business was the adoption of resolutions of sympathy for our sister department, St. John's College, Department of Arts and Sciences, on the loss of McDowell Hall. The resolutions were as follows:

Whereas we recognize in the loss of this old colonial building, the chief glory and honor of St. John's and one hallowed by over a century and a half of association, an irreparable catastrophe to this University, to the State of Maryland, and to the cause of education:

Resolved (1), That we extend to President Fell and the authorities of St. John's our warmest sympathies in their misfortune and our earnest hope that it may lead many generous friends to contribute so liberally that a greater and more glorious McDowell Hall, may arise Phœnix like from the ashes.

(2) That we pledge ourselves to do everything in our power to secure this result, and hereby direct our Committee on Endowment to open a subscription list among our alumni and the citizens of Baltimore.

(3) That a copy of these resolutions be sent to Dr. Fell and also given to the press.

Dr. John C. Hemmeter delivered an address advocating the creation of a Board of Alumni Counsellors. Although Dr. Hemmeter did not speak officially for the Board of Regents, still he suggested that such a proposition would receive favorable consideration by that Board. This would mark a distinct step forward by the University, and no doubt would be greatly appreciated by the alumni. There has and is still a feeling that the members of the Faculties of the University do not desire any outside interference, and that the University is a closed corporation run for the benefit of the professors. Such a gracious act as the countenancing of a Board of Alumni Counsellors would at once dispel this distrust. A motion was made by Dr. Wilkinson, and amended by Dr. Taneyhill, that the chair appoint a Committee of Ten to consider the matter and report at the next meeting. This motion was seconded by Dr. Hynson.

The next order of business was a resolution equally as pregnant for the welfare of the University as that just mentioned. This was proposed by Dr. Hopkinson, and seconded by Dr. N. Winslow, and was as follows:

Whereas the progress of the University of Maryland appears to be greatly impeded and its participation in the great educational foundations prevented by the present organization of the governing body; be it

Resolved, That the General Alumni Association of the University of Maryland implores the

Regents to take such steps as will remedy the existing conditions by the election of a paid Provost or President, with a governing body independent of the teaching bodies.

A motion was made and passed that a committee of three be appointed by the chair to revise the rules and regulations.

The following officers were elected for the ensuing year: President, J. B. Thomas, Ph. G.; First Vice-President, Isaac Davis, M. D., D. D. S.; Second Vice-President, James E. Carr, Jr., LL. B.; Third Vice-President, J. Fred Adams, M. D., St. John's; Fourth Vice-President, Randolph Winslow, M. D.; Fifth Vice-President, J. W. Westcott, Phar. D.; Treasurer, Daniel Base, Ph. D.; Secretary, Chas. G. Sadtler, M. D.

Executive Committee—Dr. B. Merrill Hopkinson; L. W. Farinholt, D. D. S.; H. P. Hynson, Phar. D.; J. H. Skeen, LL. B.; Jacob Bird, M. D., St. John's.

Endowment Committee—E. F. Cordell, M. D.; Judge Henry Stockbridge; C. V. Matthews, D. D. S.; Leroy Robinson, Ph. G.; L. B. K. Claggett, St. John's.

According to a ruling of the chair, the presidency rotates among the various departments, and as Law, Medicine and Pharmacy have had a representative in the chair, the next incumbent will be a representative of Dentistry, and two years hence a graduate of the Department of Arts and Sciences.

Dr. Hiram Woods was recently registered at the Chalfonte, Atlantic City.

Dr. St. Clair Sprnill has returned from Atlantic City, where he was recuperating from an attack of appendicitis.

Dr. Norman Dudley, class of 1901, of Church Hill, Md., recently visited the Hospital. Among other recent visitors were Dr. Rollin Jefferson, Jr., of Tampa, Fla., and Dr. Byron W. Eakin, class of 1903, of West Virginia.

Dr. Claude Van Bibber, class of 1877, of Baltimore, one of the best known physicians in the city, has been seriously ill at his home, 9 E. Read street, as the result of a fall several weeks ago. During the last snow Dr. Van Bibber was called out late at night and slipped on the ice. He paid little or no attention to the accident until several days later, when he complained of severe pains, and was forced to go to bed. Though 52 years of age, Dr. Van Bibber is a man of strong and healthy physique.

Dr. Van Bibber married Miss Margaret Cohen, daughter of Judge M. M. Cohen, late of the Supreme Bench of Louisiana. They have three children.

Mr. T. A. Joynes, of 2330 Eutaw place, announces the engagement of his daughter, Miss Julia Armistead Joynes, to Dr. Arthur Marriott Shipley, of Baltimore. The wedding will take place in June.

Dr. Shipley is a native of Anne Arundel county, Md., and took his degree of medicine with the class of 1902, University of Maryland, of which institution he is now an associate professor. After his graduation Dr. Shipley held the post of assistant surgeon at the University Hospital until June, 1904, when he was appointed medical superintendent, which position he held until June, 1908.

The Alpha Chapter of the Kappa Sigma Fraternity, University of Maryland, received at the Fraternity House, 130 West Lanvale street, recently. The house was decorated with smilax and cut flowers. After the reception there was a dance.

Dr. Walter Wickes, class of 1900, and Mrs. Wickes have taken an apartment at the Washington and will make their permanent home in Baltimore.

The following of our alumni are on the State Board of Health of Maryland:

Secretary and Executive Officer — Dr. Marshall Langton Price, class of 1902, 10 South street, Baltimore.

Laboratory Assistant—Dr. Harry W. Stoner, class of 1907, 1826 East Monument street, Baltimore.

Bacteriologist—Dr. Wm. R. Stokes, 1639 North Calvert street.

Dr. John A. Tompkins, class of 1898, is lieutenant and surgeon, Maryland Naval Brigade.

The following of our alumni are county health officers:

Anne Arundel—Dr. James J. Murphy, class of 1896, of Annapolis; First Precinct, Fifth District, Dr. H. Brooke, Brooklyn, class of 1891.

Baltimore County—First District, Dr. Arthur H. Mann, Jr., class of 1890, Catonsville; Third District, Dr. H. A. Naylor, class of 1900, Pikesville; Fourth District, Dr. Harry M. Slade, class of 1884, Reisterstown; Fifth District, Dr. B. F. Price, class of 1857, of Mt. Carmel; Sixth District, Dr. John B. Norris, class of 1866, of Beckleysville; Seventh District, Dr. E. W. Heyde, class of 1892, of Parkton; Ninth District, Dr. R. C. Massenberg, of Towson; Eleventh District, Dr. James F. H. Gorsuch, class of 1876, of Fork; Twelfth District, Dr. W. C. McClannahan, class of 1902, of Highlandtown.

Caroline—Dr. Enoch George, class of 1872, of Denton.

Carroll—Second District, Dr. Luther Kemp, class of 1887, Uniontown; Sixth District, Dr. John F. B. Weaver, class of 1864, Manchester; Seventh District, Dr. Charles R. Foutz, class of 1897, Westminster; Eighth District, Dr. Richard F. Richards, class of 1897, of Hampstead; Ninth District, Dr. Edwin D. Cronk, class of 1884, of Winfield; Eleventh District, Dr. George H. Brown, class of 1864, of New Windsor; Twelfth District, Dr. James Watt, class of 1863, of Union Bridge; Thirteenth District, Dr. W. F. Gaver, class of 188—, of Mt. Airy.

Dorchester—Dr. Guy Steele, class of 1897, of Cambridge.

Garrett—Dr. H. W. McComas, class of 1888, of Oakland.

Harford—Dr. W. B. Kirk, class of 1893, of Darlington.

Queen Anne's—Dr. A. E. Landers, class of 1907, of Crumpton.

Talbot—Dr. E. R. Trippe, class of 1862, of Easton.

Washington—Dr. J. E. Pitsnogle, class of 1889, of Hagerstown.

Wicomico—Dr. Charles R. Truitt, class of 1891, of Salisbury.

The following of our alumni are town health officers:

Aberdeen—Dr. Charles R. Kriete, class of 1895.

Brunswick—Dr. Levin West, class of 1886.

Cambridge—Dr. J. C. Travers, class of 1895.

Cumberland—Dr. George L. Carder, class of 1891.

Easton—Dr. Philip L. Travers, class of 1902.

Frostburg—Dr. J. M. Price, class of 1890.

Kensington—Dr. Wm. L. Lewis, class of 1892.

Laurel—Dr. W. F. Taylor, class of 1884.

Dr. Marshall L. Price, class of 1902, is a member of the State Board of Health of Maryland.

Dr. Guy Steele, class of 1897, of Cambridge, is one of the managers of the State Tuberculosis Sanitarium, located at Sabillasville.

The following of our alumni are members of the Board of Medical Examiners of Maryland: Dr. Herbert Harlan, class of 1879, of Baltimore; Dr. W. W. Goldsborough, class of 1901, of Greensboro.

The following of our alumni attended the last meeting of the Book and Journal Club, held at the Medical and Chirurgical Building: Dr. Hiram Woods, Dr. J. Whitridge Williams, Dr. H. M. Thomas, Dr. William Royal Stokes.

Dr. W. D. Scott, class of 1905, is vice-president of the Baltimore Alumni Association of the Virginia Military Institute. He is also on the banquet committee.

Friday, February 26, 1909, Dr. T. Chew Worthington, class of 1876, read a paper entitled "The intranasal frontal sinus operation. The accessibility of the sinus and the prognosis of the operation," before the Section on Laryngology and Rhinology.

Dr. William H. Welch was the guest of honor recently at a banquet tendered him by the Beta Alpha and the Beta Beta Chapters of the Nu Sigma Nu Fraternity at the Belvedere Hotel. The banquet was served in the tearoom of the

hotel, and the tables were resplendent with cut flowers and trailing asparagus. Dr. Harvey Cushing acted as toastmaster. Speeches were made by Dr. John C. Hemmeter, Dr. J. M. T. Finney, Dr. Samuel Chew and Dr. H. M. Thomas. Some of the invited guests were Drs. J. J. Abel, Hiram Woods, J. Mason Hundley, Jacob Bird, Joseph Hart, Jose L. Hirsh, H. C. Davis and T. Harris Cannon.

Dr. Timothy O. Heatwole, class of 1897, City Councilman from the Twelfth Ward, who resides at 2003 North Charles street, has been confined in the University Hospital with appendicitis.

The last meeting of the Baltimore County Medical Society was held in the hall of the Alert Engine Company, and was addressed by Dr. Hiram Woods. Among those present were the following of our alumni: Drs. H. D. Cox, Arlington; William D. Corse, Gardenville; Hiram Woods, Baltimore; James H. Wilson, class of 1868, Fowblesburg; Josiah S. Bowen, Mt. Washington; Harry G. Naylor, Pikesville; H. Louis Naylor, Pikesville; E. A. Jones, Baltimore county; L. Gibbons Smart, Lutherville; J. M. Hundley, Baltimore; R. C. Massenburg, Towson.

Dr. John R. Winslow has returned from Richmond, Va., where he presented a paper to the American Laryngological, Rhinological and Otological Society.

Dr. L. J. Goldbach writes to THE BULLETIN: "My attention has been called to the fact that a statement in my article on the ear polyp in THE HOSPITAL BULLETIN of the January number, is liable to be misinterpreted, so I respectfully request space to make matters clear.

"The statement reads: 'Our method of treating the aural polyps at the Presbyterian Eye, Ear and Throat Hospital is by means of 10 per cent. formalin irrigations (10 gtts. to a half tumbler of warm water). I had no idea of meaning that 10 per cent. formalin could be used without dilution; rather, one-half tumbler of warm water (practically 4 oz.), to which add 10 gtts. of a 10 per cent. solution of formalin, this making the injecting fluid about 1-2000.'"

At a meeting of the Anne Arundel County Medical Society, held February 9, 1909, the following of our alumni were elected to office for the ensuing year: Vice-President, J. Oliver Purvis, M. D.; Treasurer, Frank H. Thompson, M. D.; Secretary, Louis B. Henkel, M. D.; Censor, J. S. Billingslea, M. D.; Delegate to the State Faculty, C. R. Winterson, M. D.

At the last meeting of the University of Maryland Medical Association, held in the amphitheatre of the University Hospital, Tuesday, February 16, 1909, at 8.30 P. M., the program was as follows:

1. The Gonococcus. Its Toxins and Paths of Infection—Mr. W. F. Weber, of the Senior Class.
2. Systematic Infections due to the Gonococcus—Dr. Harry Adler.
3. Treatment of Acute Gonorrhoea—Dr. Page Edmunds.
4. Treatment of Chronic Gonorrhoea—Dr. W. D. Scott.
5. The Treatment of Gonorrhoea in the Female—Dr. Hugh W. Brent.

The twenty-third annual reunion and banquet of the Princeton Alumni Association was held February 27, 1909, at 2 West Eager street, Baltimore. Among those present were the following of our alumni: Dr. Hiram Woods, Dr. Silas Baldwin, Dr. C. W. Mitchell. Dr. Hiram Woods was elected a member of the executive committee.

Dr. Fell writes: "Dr. Nathan Winslow—I am very much obliged for your very kind letter of sympathy in our recent severe loss. In many

ways it is irreparable, but I hope that one good effect growing out of it may be a development of a strong feeling for the University of Maryland, making us of one interest and of one mind. The members of the other Faculties have been most kind in the feeling they have expressed."

Dr. Edgar G. Ballenger, class of 1901, is editor of the *Journal-Record of Medicine,* published at Atlanta, Ga.

Among our alumni subscribers to the annual banquet of Loyola College were the following: Dr. Louis W. Knight, Dr. L. J. Goldbach, Dr. J. J. Carroll, Dr. T. J. O'Donnell, Dr. F. A. Kirby, Dr. Charles O'Donovan, Dr. W. F. Schwartz, Dr. E. F. Milholland, Dr. L. E. Neale, Dr. M. A. O'Neill.

In a letter to Professor Randolph Winslow, Dr. T. Rassy, class of 1902, says, in part: "Lately I received a letter from my nephew, Jenil Rassy, who is now in the University. Jenil thinks that the University of Maryland is ideal, and he is sorry he did not go there sooner. Jenil tells me that the University has wonderfully improved. I am very glad and happy to hear it, as nothing makes me more delighted than to hear of the progress of the dear old University of Maryland." He goes on to ask of the various instructors with whom he was acquainted, and continues: "Since I left Baltimore I went to Constantinople, where I received my Ottoman Permit, and then returned home to Syria, where I practiced privately for about 15 months. In September, 1904, I joined the Egyptian Army as a member of the Medical Corps, and here I am still an officer in His Highness the Khedive's Army." He then says he intends remaining in the Egyptian service for at least five years longer.

Dr. Arthur E. Ewens, class of 1904, of Atlantic City, N. J., writes Professor Randolph Winslow: "I am very glad to be able to tell you that my wish for the appointment on the surgical staff of our hospital has been gratified. The Governor's meeting was held at a later date than I had supposed. I want again to thank you for the valuable assistance afforded me by your letter."

The handsome residence of Dr. Edward A. Wareham, class of 1883, on Potomac avenue, Hagerstown, was destroyed by fire February 4, 1909, entailing a loss of $20,000, partially covered by insurance. Dr. Wareham's three children were compelled to flee from the burning building in their night clothes. The fire, which started in the attic, was thought to be due to crossed electric wires.

Dr. James S. Fox, class of 1907, of Charleston, S. C., a former house student and ex-resident in the obstetrical department, has been appointed a lieutenant in the Medical Corps of the United States Army. He was one of the 14 successful out of a total of 56 candidates at the recent examinations for entrance to this branch of the government service.

Dr. J. Holmes Smith has been appointed surgeon to the United Railway service connected with the University Hospital.

Dr. H. M. Fitzhugh, class 1897, now practicing his profession in Westminster, Md., with success, has been a recent visitor to the University Hospital. Dr. Fitzhugh was formerly a resident physician to the Hospital, and he enjoys his visits to his former haunts.

Dr. T. S. Latimer, class of 1907, is now a successful practitioner in Hyattsville, Md. Dr. Latimer recently visited the Hospital.

Dr. Alexander D. McConachie has been appointed eye and ear surgeon to the Union Hospital of Cecil county, at Elkton, Md.

Dr. J. J. Taylor, class of 1908, of Madison, N. C.; Dr. John Bizzill, class of 1908, of Tampa, Fla.; Dr. Keavy Pearlstine, class of 1906, of Charleston, S. C., and Dr. John S. Kerr, Jr., class of 1908, of Wilmington, N. C., have been recent visitors to the University Hospital. These recent graduates of the University believe that an occasional visit to alma mater is beneficial in many ways.

The Bulletin is always glad to see the alumni of the University around the Hospital. It is a good sign when our former students come back to the Hospital to freshen up their clinical work.

The final meeting of the Executive Council of the Centennial Committee was held at the residence of Prof. John C. Hemmeter on Tuesday, March 9. The object of the meeting was to audit the accounts of the treasurer. After the paying of the cost of publishing the Centennial Volume and the designing, casting and erection of the James Carroll memorial tablet, there was reported a small balance in the Calvert Bank.

The auditing was done by Dr. B. Merrill Hopkinson, Dr. T. O. Heatwole and Dr. I. H. Davis. The committee voted that the small balance should be left at interest in the Calvert Bank in order to defray expenses of sending the Centennial Volume to the university libraries of this country, Canada, Europe, etc.

MARRIAGES.

Dr. Briscoe Ranson, class of 1902, son of Dr. B. B. Ranson, of Harpers Ferry, and Miss Daisy Yarbrough, of Staunton, Va., were married in the First Presbyterian Church, at Staunton, recently. They will reside at Maplewood, N. J., where the groom has been practicing medicine for several years.

The Virginia papers described the Ranson-Yarbrough wedding, which was celebrated at Staunton, Va., on Thursday, February 4th, as being one of the most beautiful of the season.

The contracting parties were Miss Daisie Yarbrough, of Staunton, and Dr. B. B. Ranson, Jr., of Maplewood, N. J. The wedding ceremony was performed at the First Presbyterian Church at 6 o'clock, and the decorations were simple, but most effective, being composed entirely of handsome palms and white candles. A brilliant reception was given at the home of the bride, and later Dr. and Mrs. Ranson left on an extended tour. They will reside in Maplewood.

Dr. Ranson graduated in the Medical Department, class of 1902. He was a man of great popularity, and has since attained marked success in the practice of his profession.

Dr. F. Garnett Cowherd, class of 1908, of Mount Savage, son of Mr. and Mrs. William Cowherd, of Cumberland, and Miss Amie Louise Perdew, daughter of Prof. and Mrs. George M. Perdew, were married this evening at the home of the bride by Rev. William Cleveland Hicks. Miss Ruth Perdew was bridesmaid and Mr. Algernon Hardy, of Washington, a cousin of the groom, was best man.

DEATHS.

Dr. Harry T. Talbott, class of 1887, son of Mr. and Mrs. H. O. Talbott, died at his home February 26, 1909, after an illness of some weeks, aged 42. He is survived by one daughter—Miss Lillian Talbott—and one sister—

Mrs. John F. Buckner, of Washington. Dr. Talbott's wife, who was Miss Lillian Hedges, of Frederick, died some years ago. His body will be interred in the latter place.

Dr. J. H. W. G. Weedon, class of 1864, one of the most widely known physicians of the Eastern Shore of Maryland, and once a member of the Legislature, died Wednesday, February 17, 1909, of Bright's disease, at the University of Maryland Hospital. Dr. Weedon was 74 years old, and lived at Church Hill. For two weeks Dr. Weedon had suffered acutely from Bright's disease, and recently decided to come to the University Hospital. Dr. Weedon weakened steadily, and died about 1.30 o'clock in the afternoon.

Dr. Weedon ws born on Kent Island, September 1, 1835, and was the son of the late Henry and Rebecca Legg Weedon. He studied medicine and was graduated from the University of Maryland, after which he returned to Kent Island, where he practiced and became interested in politics. He represented the Democratic party in the Legislature of 1882. In 1885 he left the island for Church Hill, where he devoted most of his time to practice. His only immediate survivor is his widow, who was formerly Miss Mary R. Thompson. The body will be taken to Church Hill for interment.

Dr. Edmund G. Waters, class of 1853, of Baltimore, 79 years old, 1711 Madison avenue, died recently. He was the son of Dr. Francis Waters, of the Methodist Protestant Church, and was born in this city. Dr. Waters studied in the office of Dr. Nathan R. Smith, and was graduated from the University of Maryland in the class of 1853. He married the daughter of Dr. William Hitch, and he first had an office on Hollins street, where he engaged in the practice of his profession. When the Civil War broke out Dr. Waters was appointed assistant surgeon at the Camden Hospital, and served there and at Jarvis. He afterwards became professor of chemistry at the Baltimore High School, remaining there until he moved to Dorchester county, near Cambridge, in 1868. In 1882 he returned, and again engaged in practice until the breaking of his leg incapacitated him from active work.

Mrs. Norris, wife of Dr. J. B. Norris, class of 1866, sanitary officer of the Sixth district, died recently at her home, at Beckleysville. She is survived by her husband and two daughters. Before her marriage she was Miss Gardner.

Dr. Edmund Cantwell Gibbs, of Baltimore, died at his home, 316 East North avenue, as the result of Bright's disease. Dr. Gibbs was born near Middletown, Del., on September 17, 1856. He was the son of the late Benjamin and Hannah Justice Gibbs, of Delaware, and descendants, respectively, of early English and Swedish settlers. After leaving the Middletown Academy, in Delaware, Dr. Gibbs took up pharmacy. After several years of work at this profession he came to Baltimore and entered the Medical Department of the University of Maryland. He was graduated in 1884.

In the last year of his collegiate course Dr. Gibbs was resident student at the University Hospital, and for several years was surgical dispensary assistant. He was a member of the Medical and Chirurgical Faculty of Maryland and medical examiner of the Shield of Honor.

Besides his wife, Mrs. Lulu C. Gibbs, Dr. Gibbs is survived by five children—Joseph S. Gibbs, of Wheeling, W. Va.; Isaac Gibbs, of Kent county; Anna Dale, Gustavus J. and Catherine J. Gibbs. The funeral services will be held at the late home of the deceased tomorrow afternoon at 2 o'clock. The body will be taken to Middletown, Del., where burial will be in the family graveyard in Old St. Ann's Churchyard.

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THE ETHICS OF THE GENERAL PRACTITIONER.

An Address delivered Before the University of Maryland Medical Association, March 16, 1909,

By GUY STEELE, M. D.
Of Cambridge, Md.

A celebrated divine once said that the most difficult part of a sermon was the selection of a proper text. I must thank the President of this society for saving me this trouble. When, however, Webster's is consulted for a proper definition of the word "Ethics," and it is found to mean "The science of human duty," it would seem that he has chosen a text almost too comprehensive for the limits of a short paper, even when restricted to the "ethics of the medical profession." It may not be out of place to thank him for the honor he has conferred upon me by deeming one whose student days are scarce twelve years behind him worthy of presenting this subject to you, for a paper on this topic is almost of itself a sermon, and we naturally look up to those, whose many years of experience and works have brought them prominence, for instruction in morals and duty. Still, I take it, whether young or old, all of us like to preach on fitting occasions, and not the least part of the inspiration to effort is the character of the audience. My invitation was to read a paper before the Clinical Society, and incidentally I was told that some of the students had expressed a desire to be present. Little, however, did I anticipate such a flattering attendance from them when examination time so nearly approached, and it is evidence of a most commendable spirit when they can bring themselves to take even an hour of their most valuable time from study to devote to a consideration of the moral duties and responsibilities which shall be theirs when they shall have passed through the April ordeal. Much that I have to say tonight will be directed especially to them, and if they or their elders in the profession may in the years to come look back upon this night with the recollection that I have more forcibly brought to mind some of the old and half-forgotten maxims and axioms that make for a better and purer professional life, I will have been more than repaid for the time I have expended in the preparation of this paper.

In discussing the ethics of the general practitioner towards his patient, I would have you remember that your first and most important duty is to give to those who trust you the very best that is in you.

To you young men, full of enthusiasm for your new profession, and imbued with Utopian ideas of the mission which you have undertaken for the good of mankind, it would seem almost foolish for me to mention this as the first advice I would offer you. But I think I can see a smile of understanding flit across the faces of those who have for some years fought the battle of life, and who have had the wire edge of early ambitions and determinations blunted by contact with unappreciative patients and unworthy professional competition and the daily incidents of a busy life. They know that it is very easy to feel too tired, or be too busy, or have some other engrossing affair in mind which prevents that entire devotion to duty which all admit is essential to success in medicine. Half of success in life or in any undertaking is due to a successful start; therefore, let me ask you to firmly determine on one or two fixed principles, and to stick to those principles through thick and thin. Be fully assured that no halfway devotion to your profession will ever bring you prominence or success. The time-worn phrase that "Medicine is a jealous mistress" loses none of its truth by frequent repetition. Recently I saw in a prominent medical journal the advice given that doctors should take a prominent part in politics and bring themselves forward in other ways, and that thereby in some way unknown to me

the glory of the profession would be enhanced, and much benefit result to the community. Far be it from me to discourage a proper civic spirit and a proper interest in public affairs, or to advise an avoidance of any duty which good citizenship imposes upon every honest, patriotic man, whatever his business or profession. But I take it that no more baneful, no more dangerous advice can be given to our young professional man than this. You cannot be successful in both politics and medicine, and while we can point to one member of our profession in the United States Senate, and to some notable exceptions in our own State, where men of our profession have, for a time, abandoned medicine and returned to it to win success, you can rest assured that the medical politician possesses little beyond a musty diploma to remind the world that he was once of our cult. So don't be a halfway politician and halfway doctor. Success in either field will take all of your best effort and all of your time.

What I have said of politics will apply, though not quite so forcibly, to any other engrossing business or pleasure. Time forbids me to elaborate this idea, and in concluding it let me say that you cannot be a successful politician, merchant, sport or what not and carry medicine as a side line.

It may seem useless to remind you that, in order to give the best that is in you, you must keep abreast with what is new and best in professional literature and scientific progress. You all have determined to be students, and even those who pride themselves on having passed through the University without having opened a book have a half-formed desire to really know something beyond spotting a possible examination question, and when once examinations are over, and they have reluctantly withdrawn themselves from the delights of the city by gaslight for the pine woods and mountain trail, they will burn the midnight oil and browse diligently through their musty tomes. May I tell you that nothing is harder than to find time for study. Many of us, even though city men, with the best and latest literature at our elbows, are ashamed to think how thoroughly we abhor the sight of a medical book or magazine, and how easily we can persuade ourselves that we are too tired and stale, and so engrossed during the day with scenes of sickness and suffering that we must have our brief hours of release from duty for recreation. We do need our hours of relaxation and rest and our too infrequent holidays, and they are absolutely essential to good health and good work. Don't, however, confuse the words rest and relaxation with sloth and idleness, and don't think your professional work completed when your round of daily visits is done. Indeed, if you would know medicine you must woo your mistress in the small hours of the night, and in many of the leisure moments that the day may bring you.

Much has been spoken of the man who practices by common sense, and whose school has been that of observation and hard experience. A most worthy brother he is at times, and many are his friends and wonderful his success. But if the science of medicine is to advance, more is required for progress than mere common sense, and observation untrained and experience undirected and unguided by the observation and experience of others will rarely discover a new bacillus or elaborate a side chain theory. So, to be truly ethical in the duty you owe to give the best that is in you, you should be reading men. Take one or more of the medical journals. Buy for reference the latest and best text-books. Make the opportunity to read the daily papers and something of current literature. A well-rounded man can afford to do nothing less. Besides the information you obtain, it pays in the respect of the community to have the reputation of being posted in your profession. Often the country man simply hasn't time at home to read. A busy life, with its miles upon miles of dusty roads to travel, precludes all chance for the easy chair. Then cultivate the habit of reading while driving. Many are the useful and happy hours I have spent in my carriage with my journals and magazines. I am frank to say that, but for this habit, I never could have found time for one-half of the reading I have done. Last year I was somewhat amused when a most worthy, well-educated and well-posted man summed up his opinion of another by saying that he was one of those who read magazines in his carriage. If I mistake not, this indictment was brought against the late Dr. Miltenberger, who as a young and busy

man was forced to form this habit, and I could but think that, could I die with half the honor and respect and love that were his, I could plead guilty to even this mark of devotion to my profession and desire to advance in it.

Would you be ethical in giving the best that is in you to your patients, you must give ungrudgingly of your time. This may again seem a useless piece of advice, and yet almost all of us are familiar with the man whose motto is "Veni, Vidi, Vici"—"I came, I saw, I conquered." This intuitive diagnostician is by no means a myth. The man who comes in a rush and goes in a rush, and who, with pencil in one hand and prescription pad in the other, feels the pulse while the thermometer is under the tongue; who sees at a glance, without necessity of personal or family history or of physical examination, just what is the matter, and who, giving four or five prescriptions, rushes out, trusting that something in his shotgun therapy may hit the enemy. Perhaps the next day he prescribes four or five more remedies or combination of remedies, and should the patient begin to improve, prides himself that he has made and confirmed a diagnosis by his experimental therapy. Is it necessary for me to say that no ethical man with any regard for the rights of his patients and his obligation to his profession can really practice medicine in this manner? The plea that you are too busy to give the proper time to your cases is no justification for your neglect. Anything less than a careful inquiry into family and personal history, followed by a painstaking and thorough physical examination, is unjust to your patient and unjust to yourself. No ethical man can give the best that is in him by doing less than this. If you haven't the time to do your work thoroughly, make a clean breast of the matter and take fewer cases. But you will say that a man, even in large practice, cannot afford to give any of it up. He needs every dollar that honestly comes his way, and to say that he hasn't time for his work is only another way of throwing practice into the hands of a rival. This is, indeed, a proposition hard to solve, as most of us do need every dollar that honestly comes our way; but if our work is only half done, if we have neglected some important point in diagnosis, and thereby omitted some equally important measure in treatment, have our dollars been honestly earned? Let us start out with and carry in mind this axiom of a truly ethical life, that success in medicine cannot be measured by commercial success; that, while no sensible man can neglect the business side of his vocation, or refuse to demand and collect just compensation for his service, such compensation cannot be measured in dollars and cents alone; that a good conscience and whole-souled devotion to duty, giving ungrudgingly of the very best that is in you to those that have confided in you, will be your very best asset when the final account is made up.

May I impress the fact upon you that an ethical man, with a just appreciation of his duty to his patients, can never be a vendor of patent or unofficial medicines. Indeed, I would be lacking in my duty if, with the opportunity this paper offers me, I did not, from the standpoint of experience, impress upon you with all of the force at my command the necessity of being wary of the detail man and the alluring advertising literature with which your mail will be flooded. You will scarcely have opened your office, and be waiting with what patience you can command that rush of the halt, the lame and the blind to which you feel that your talents entitle you, before the suave detail man, having heard of the new field, puts in his appearance. What you lack in therapeutic experience he can supply you by drawing liberally on the experience of others who have worked little less than miracles in an adjoining town by the use of his pills and potions, his elixirs and tinctures. You will find him smooth and oily, placid and plausible. He knows his story well, and even by his much speaking can almost persuade you that what you knew, or thought you knew, or what you had recently been taught, were all out of date; that by some stroke of genius the chemist of his house had discovered some way by which compatibles would combine with incompatibles into the formation of a new and staple mixture, possessing all of the virtues and none of the defects of its original constituents, rendering chloral as soothing as the strings of a lute and as harmless as the cooing of a dove, extracting from cod-liver oil every disagreeable feature and leaving nothing but its supposed virtues behind. He will show you the short road to fortune and success. Treat him kindly; the ethical man should not be rude, and brusqueness is not a sign of Roman honesty or virtue. Be as-

sured he feels his position keenly, and is dreading the catechism which will sooner or later display his ignorance of everything but the story that has been drilled into him like a parrot.

There has been no greater shame in our profession than the influence these men and their houses have exercised, and incidentally the indorsements and recommendations that thoughtless men have furnished them. The blame is all ours, and we cannot shun it. We pride ourselves on our scientific attainments; that we take nothing for granted; and, now that the age of empiricism has passed, we accept nothing that does not bear the stamp of scientific approval. And yet, before the campaign of the American Medical Association and the revelations of Collier's and the Ladies' Home Journal, we accepted our treatment from the hands of the manufacturing houses, and dosed our patients with nostrums about which we knew nothing except the statements of those whose sole purpose it was to sell. There are few of us who have been many years in practice to whom a blush of shame does not come at the recollection of our gullibility and our guilty innocence. Can any man deem it ethical to give even to a good dog something about which he was totally ignorant? And yet this is just what we were doing. A short time ago a particularly shrewd detail man was discussing this very point with me, and claiming that, as the formula was now required by law to be printed in each bottle and package, this most formidable objection could not now hold good. Handing me a bottle of his patent cure-all, he glibly called my attention to the six or seven ingredients, with the amount of each contained in the fluid ounce. Among other potent quantities I can recall 1-48 gr. of morphia and 1-240 gr. of strychnia. The dose was a teaspoonful three times a day. Any man can imagine the more than homeopathic effect of 1-48 gr. of morphia divided into eight doses. These well-known and well-tried drugs were not, however, the life of the nostrum, and presently we came to the twenty minims to the fluid ounce of the fluid extract of the drug from which the remedy derived its name. Something I had never heard of. Something unlisted in the U. S. P. Something discovered and owned and controlled by this house alone. As my ignorance became more apparent his eloquence increased, and I have no doubt that a few years ago, before my moral conscience had become aroused to the therapeutic sin of prescribing something whose botanical family, whose chemical formula, and even whose physiological effects were totally unknown to me, I would gladly have accepted a sample and would have tried it on some poor soul too poor to pay for a prescription. It is nothing short of a shame to think of what we have done in this line. The sin has been one of carelessness and laziness rather than of ignorance. Here we had ready to hand some remedy, beautiful to the eye, palatable to the tongue; then why take the time and trouble to bother about constructing a formula of our own when someone else of equal experience had constructed one for us? I am ready to thank God that most of these nostrums are as harmless as they are beautiful, and, while I may not have done good, I rarely did harm by their use. I am not discussing the opium and cocaine laden classes. I wish to emphasize incalculable harm that must result to the physician himself who allows someone to do his thinking for him. I am also referring to the attitude of the ethical man to his patient, and beg to ask if we are doing even part of our duty when we are doing no harm. Allow me to conclude this topic by asking you to spend an hour some day in casually glancing over (a deep study would fully repay you) the pages of the U. S. P., or a list of the remedies that have in one year received the sanction of the Council on Pharmacy of American Medical Association. If you don't find enough drugs and combinations to meet every case and every conceivable situation, you had better desert practice and exploit some wonderful cure-all as a detail man.

If we, as physicians, had nothing but our duty to our patients to consider, and incidentally our own profit and glory, the practice of medicine would soon degenerate into a mere trade. I may even say that, had we nothing but the promptings of our consciences to keep us in the straight and narrow path, if we had nothing but the knowledge of work well done, and if the desire and determination to give the best that is in us were our only incentives to an ethical life, the profession would be so beset by the temptations of commercialism, and the

notoriety and prominence which commercial success brings, that the halls of Esculapius would soon need a scouring and purging greater than Hercules gave the Augean stables. Despite the high incentive to all that is best and purest in life which our noblest of callings should beget in us, physicians are only human, and human weakness, like disease, is no respecter of persons or of callings. It may have been that the medical fathers, with a knowledge of the temptations to which they were subjected, and a desire to save others from the pitfalls which beset their paths, were imbued with a determination to place their profession on a higher plane than others; or it may have been the natural evolution which inevitably resulted from and followed the promptings of man to help his fellow-man, to devote himself to the relief of pain and sickness, to sacrifice his comfort and ease and almost every pleasure in order that others might have ease of body and peace of mind and soul, which from the earliest days have placed medicine as a profession apart, and have imposed upon those who have entered its ranks certain standards of conduct and insisted on certain ethical relations which have lifted it above mere questions of gain and the vain acquisition of renown. We have been taught that Hippocrates himself was great not only as a physician, but greater still as an ethical teacher who has left with us certain maxims and proverbs which, though handed down through the ages, have lost none of their truth and none of their spotless morality. Even in the Middle Ages, when learning, not to say science, had sunk into such an abyss of ignorance that the ability to write one's name lifted one into the ranks of the educated, when human ills were relieved more often with the sword than with the scalpel, the leech was a man apart. His education, his scientific investigations, and even his supposed communion and partnership with the evil one, placed his on a pedestal above other professional callings. Then, as now, though men might scoff at our profession of superior knowledge and skill, when "pallida mors" stalked abroad or knocked at the hovels of the poor or palaces of the rich, all arose to call us blessed. It has been often said that, could a medical man live up to the ethical standards of his profession, his chances without creed or priest would not be small at the last great day. But with all of our high ideals we are only mortal, and we know and have sorrowed at the fact that many of our ethical standards are not lived up to, and that the Hippocratic law is frequently more honored in the breach than in the observance.

We have in every community where one or two are gathered together in the name of medicine the man who is everything to your face and everything else behind your back; who damns by faint praise; who sympathizes with you in your sorrows and trials, who visits the family of the patient you have lost to assure them of your skill and to insist that everything was done that could have been done, "but"—— and that one harmless little conjunction, meaning nothing in itself, is more eloquent than a thousand terrible adjectives or burning, blistering adverbs or participles. So many things can be said by the pious uplifting of the eyes, the sanctimonious upturning of the palms. He would not for the world leave a doubt in the minds of your people, and, no matter what in his inmost heart he thinks of your mistakes (from his standpoint), it is not his place to injure a brother, but, alas! he is not responsible for the unguarded tongues of his friends, and he usually sees that they do his work well for him. Often it is "if I could only have reached him earlier," which, being interpreted, means a miracle would have been wrought. Almost every community has its miracle worker, its medical resurrectionist. His cases are always a little worse than others, his victories a little more wonderful. Where you have a bronchitis, he has a desperate pneumonia, your transitory albuminuria is with him acute Bright's, and hopeless cases follow him to undo him, only to meet defeat at his skillful hands. You hear that Mr. A. is desperately ill with pneumonia on Monday, and on Friday you meet him on the street, looking hale and hearty, firmly believing that, had Dr. X. been one hour later in reaching him, he would ere this have been gathered to his fathers. Should you mildly suggest that some error in diagnosis might have been made, that even the best of us at times go wrong, and that resolution in true pneumonia could hardly be expected in four days, you will find that he has been prepared for you, feeling that Dr. X. has used some potent remedy as yet unknown to you and his less skillful breth-

ren, and firmly convinced that your suspicions of his case are based upon your ignorance or your jealousy of poor Dr. X., who was not there to defend himself, who had always spoken so kindly of you, and had uttered nothing worse than the harmless little conjunction "but"——

A little bragging is not a sin, and indeed is usually harmless, and in the long run reacts on the miracle worker. But the ethical man does frequently suffer from it, and it is a fact, absurd as it may seem, that the average man or woman would much prefer to be considered at death's door about three-fifths of the time—indeed, almost a walking Lazarus—than to be deemed the picture and personification of vigorous health. Dr. X. knows this, and plays upon the credulity of his patients. He frightens them to death's door, works a miracle, and has tied them to himself forever. We all have suffered from this, and will continue to do so until the little grain of truth has grown from the tiny mustard seed to the vigorous bush. Dr. X., with his faults, has his virtues. He aspires to be the busiest man, the richest man, the most popular man in his community. All of these ambitions, if properly guided, are laudable, and, indeed, while enhancing his power and prestige, may be redounding to the good of his people, for a man to be the busiest and most popular man in his profession must usually be the best posted, the most highly educated, the hardest working man, not only for himself, but for those he serves. So, while we may smile at Dr. X. and his big ways, we may love him for his virtues and forgive his small faults.

But for the man who deliberately goes to work to undermine another; who takes advantage of some temporary absence of the regular physician to ingratiate himself; who, appreciating the fact that people worried nearly to death by the illness of a loved one, will forget every obligation and desert every old friend in the hope that the new one may offer some encouragement or extend some hope, is ready for these emergencies. He carries satchels full of hope for all cases and occasions. He prescribes it liberally, diluted, however, to the point of despair because he was called in an hour too late, or because the case had already been damaged beyond his power of repair. This gentleman advances not only by his own deceit, but uses the power of church, of politics, of family influence and social opportunity, to lift himself along. Verily he has his reward, but it is not in peace of mind, not in the honor and respect of his community, but the contempt of every honest man, be he of the profession or laity. Not the least of the perplexing questions which beset the man who is trying to lead an ethical life is his duty in his relation as consultant. Indeed, there is scarcely a situation in professional life that at times presents more embarrassing possibilities, or calls for the exercise of more tact. It is a pleasure to be able to bear witness to the ability of the man who has called you to his aid, to assure the family that everything has been done that care in diagnosis and skill in treatment could demand. But what of the cases where gross carelessness or blind ignorance have hastened what might easily have been delayed or averted? There is only one way here, only one duty. Treat the man as his carelessness or his ignorance deserves. Again, you are called in consultation with a thoroughly good man who has given ungrudgingly of the best that is in him. Perhaps your superior skill in certain lines, perhaps your superior opportunity to observe a certain line of cases, have taught you something that he has not had the chance to learn. As before it was your duty to expose the careless ignorance of one, now it is your place to so give your opinion and explain your position that no possible reflection can be cast upon the other. Don't approach a consultation with the manner of a priest of Delphi. Don't pose as the fountain of all wisdom and of all experience. Indeed, in this work you will be surprised how often you will learn from him you are called upon to assist. He has seen the case for days, where you can spend but minutes with it. It is his part to bear the blame, yours to share his fame should success crown your combined efforts.

Frequently you will be called upon when a resort to surgery is demanded—not so much to perform the operation as to give your opinion as to the advisability of a certain line of procedure. Having determined what is to be done, don't assume the place of prominence. You have little by way of reputation to gain by performing an operation that you were known to be competent to perform or you would never

have been called. Let him do the work with your assistance and advice. In this way you will have gained a fast friend for future consultations, and you will have enshrined him in the esteem and confidence of his people. Therefore, help him and uplift and bear witness to his worth, and don't humiliate him by your airs and assumed superiority.

As a last word, don't consult with an unworthy man, for be assured that your reputation is worth more to you than any consultation fee, however badly you may think you need it.

The question of fees is one that must be considered. We hate to think of the combination of medicine and money, and our patients abhor it even more. The days once were when only the sons of the rich sought the liberal professions. It was thought unworthy in the days of the dim ages for a pupil of Esculapius to charge for his services. Any remuneration that came to him was an offering of gratitude—indeed an honorarium which might be tendered or withheld at the will of the patient. A truly noble conception this, that the good we offered was beyond a mere question of price. Equally comforting was the belief that the ill which resulted despite our best efforts was no reflection on our skill, but an evidence of the wrath of the Gods. Would that we were as near Olympus now as then, and that the Gods walked with men to reward the worthy and punish the unjust. Would also that the manners and costumes and climate of Ancient Greece were still with us, so that man need take little heed of raiment beyond a robe and sandals; that he required no expensive outlay for instruments, no intricate electric outfit, and no automobile. What a life ours would be if now as then our grateful patients sought us, and we passed our many hours of leisure in eloquent discussion or in lazy lounging amid the leafy groves or shaded porticos of the temples! But the times have changed, and we have changed with them, and abhor as we will the combination of medicine and money, we are forced to take thought of the morrow and to spend many, many anxious moments in this thought and in trying to evolve ways and means by which a balance can be maintained between the honoraria of patients, both grateful and ungrateful, and the claims of persistent creditors. Perhaps it is best thus, as the average man needs some incentive to good work beyond the acquisition of honor and glory. An axiom in the question of fees is this, that in order to be respected we must respect ourselves, and no one can respect himself unless he holds his calling above a trade and bases his charges upon this feeling of respect for himself and his profession. This axiom should be held in mind in arranging any fee table, and should be insisted upon in our settlements with those who think a doctor's bill should be discounted from one-quarter to one-half. I have often wondered how this right to a discount in a doctor's bill ever got such a firm hold in the public mind. Perhaps the city man cannot appreciate this fact like his country brother. The poor, honest old farmer, part of the bone and sinew of the land, expects the highest cash price for everything that he sells. If anybody has ever heard of one who when ten barrels of corn at $3.50 per barrel comes to $35, offering to take $25 for his bill, he should corral and cage this rara avis. But hundreds of us from the rural districts have been deemed mean and close-fisted and extortionate because we gently insist that $35 worth of professional services rendered are worth $35 and not $25.

This is largely our own fault, for so many of us present a bill in one hand and an apology in the other. We collect our bills not as if they were our just dues, but with a half-hearted insistence, inducing our debtor to believe that we have scruples ourselves as to the value of our services, and that a liberal discount from the face of the bill will about bring us to a fair settlement. It will be better for all—for patient as well as physician—to realize that the "science of human duty" implies a duty to oneself as well as a duty to the public, and that a small proportion of the charity of our profession should begin at home. To the young men I would especially give this advice: Having settled on a fair and honest fee for your services, do not depart from this fee. With us, as a rule, prosperity in the form of a numerous clientage comes sooner than to the other professions. You will not long have opened your office before you will be surprised at the number who demand your services. There will be no doubt of the demand, for those who pay the least invariably demand the most. Don't turn them away, for if you properly employ your time, you will gain in experience and occasionally a dollar or two. You will soon be enlightened as to your popularity, for the first pay day will send

most of them to another and it is presumed easier man. Many of those who stick will tell you that Dr. —— never charged but 50 cents a visit, when the regular fee is $1.00. Dr. —— will vigorously deny this and produce his books to prove his truth. Here is everything plain before you. Every visit is listed at the established figure. You will rarely see his cash book, for then the whole transaction would be plain, and you would discover the simple manner by which in every community some supposedly ethical man is supplanting his truly ethical brother by charging full fees and settling for half.

Dr. —— will cut 50 cents or a dollar from the established fees for out-of-town work, and immensely increase his practice by it. For be it understood the bone and sinew of the land dearly love the wholes and halves, and will flock to sell in the dearest and pay in the cheapest market. Don't envy this man his prosperity and, above all, don't follow in his footsteps. Bide your time with the assurance that the man who charges $1.00 for $2.00 worth of service rarely gives more than a dollar's value, and that when a real emergency arises and a capable, honest man is demanded, one who respects himself and his calling, if you have prepared yourself and are known to give the best that is in you, the cheap man will go to the wall and your merit will receive its reward. If by chance any of you have not seen Dr. McCormick's paper on this question of fees and collections, let him by all means find the proper A. M. A. Journal and read it. It is a classic worth any man's time and attention. In concluding this subject, let me endorse what he says about the cheap man, the price-cutter. Whatever his charge may be, he is usually getting full value for his services. Realizing his lack of education or ability or temperament, or whatever it is that puts him below his professional competitor, he cuts his fees in order to live. It is not our place to meet his competition, but to pity him, to extend to him the helping hand, to endeavor to elevate him to our standard, and never to lower ourselves to his.

I have only a few words to say on the subject of professional confidences. So sacred is the relation between the physician and patient regarded that the courts will not compel a physician, while on the witness stand and under oath, to tell the truth, and not only the truth, but the whole truth, to reveal what is imparted to him in confidence by his patient.

If in this exalted function of doing justice between man and man the courts will not compel the recital of some important piece of evidence, how carefully should we regard our professional relation, and see to it that neither in strict confidence or in idle gossip do we betray the secrets that suffering man has confided in us.

It may be somewhat out of place in a paper dealing with "The Ethics of the General Practitioner" to speak of the tendency, or perhaps better, the half-formed determination of the majority of every class to be specialists. I must confine myself to the predilection of the average medical student for surgery. It was so in my day, and I suppose it is so now, that almost 75 per cent. of the graduating classes are thoroughly satisfied that the end and aim of medicine is surgery; that practice and the less spectacular branches are parts of the profession essential to it as a whole, and fitted for those who intend to lead the plodding life, but too slow and too prosaic for the man bursting with the knowledge of his own brilliancy and his own special fitness. There is no question but that this tendency has done much to lower the average fitness of many classes. Men become listless and careless, neglecting everything but their hobby, and while the surgical amphitheatre is crowded, the medical clinics will be shunned, even deserted were it not that the sections are such that the absentees can be spotted and warned. There is no question also but that indifference to everything but surgery is responsible for many of the failures before the State Examining Boards. We must have surgeons, and they must begin their training in medical schools, and it is not my purpose to discourage earnest work and honest effort to this end. I wish, however, to say that every ethical specialist needs a thorough grounding in the general branches of medicine, and he should not in his student days neglect the other essentials to a well-rounded man. Most heartily do I wish to condemn the careless, happy-go-lucky manner in which so many men totally unprepared and totally unsuited by temperament for this branch "rush in where angels fear to tread." I wish especially to draw your attention to the fact that there is a vast difference between the operator and the surgeon. Almost any young man with a disregard of the sight of blood, with nerves unaffected by human suffering and a heart untouched by a knowledge of his power to do harm, can in six months' practice on the cadaver

learn to cut, to sew and to ligate with neatness and despatch. Indeed, there may be many before me of the student body whose young and nimble fingers could teach dexterity to the best surgeons of the city. Very many with no pretense to this dexterity, and no equipment but a superabundance of assurance, graduate as surgeons and assume and aspire to a position of prominence that it has taken the true surgeon years of the hardest, closest, most untiring study, observation and work to reach. We are told as an excuse for this remarkable evolution from the student to the surgeon that the young man of today is taught so much more than the old men were; that the very manner of teaching, the equipment of the schools and the superior requirements for matriculation cannot but turn out better posted and more competent men. There is much truth in this. There is much truth also in the fact that while more is taught, more, infinitely more, is demanded of the student, and the knowledge that would have secured him a diploma fifty years ago will now scarcely carry him through his freshman year.

We also hear that "I want to be a surgeon, because surgery accomplished positive results." This is very true also, and it is evident that if you amputate a leg your patient will be minus a member. Don't lose sight of another fact, however, that if without being competent to meet any unforseen emergency that may arise, you lightly open the abdominal cavity, you will have a positive result in the shape of your own little private graveyard. The newly graduated surgeon is not as dangerous as the man who left medical school years ago, before the students received one-third of the surgical training that they do now. Many of these men have not taken a post-graduate course, have never been associated with a hospital, nor have they had even an opportunity for moderate surgical observation; and yet they are attempting to do the work that only a skilled specialist should undertake. I am not speaking of emergency surgery for which any man should try to prepare himself, and be brave enough to undertake when human life is at stake. I am referring to operations of election when the services of a competent man can be secured. The point is just this, gentlemen, that medicine as a science is the result of evolution and not the creation of some brilliant brain; that what has been done in it has been accomplished not so much by inspiration as by close plodding work, exhaustive experiment and continual observation; that surgery as one of its branches cannot be mastered in the four years of student life, but that to be surgeons you must be workers and observers. It will not do to settle the matter by saying that a man must make a start. This truth is too self-evident to be smart, nor is it entirely convincing. An answer equally true will be that you will not allow the embryo surgeon to start on you, and before you put yourself or your wife or your mother in his hands you will demand that he possess some other qualification for his specialty besides his conceit, his gall and his need of the fee. There may be some exceptions where the man is born and not made, but I beg to assure you that the surgeon rarely springs full-fledged and fully fitted from the brain of Minerva.

Our profession is nothing if not altruistic. It demands daily and hourly more of self-sacrifice, more of self-devotion, than any secular calling. Indeed, the comparison is often drawn between the nobility and necessity of the duties which we perform and those of him who by divine inspiration and laying on of hands has been called to succor the diseased soul. It is not my place nor is it my purpose to enter into a discussion of this point, and I mention it only to show that we are marked men in every community; that we are placed on a higher plane and that more is expected of us than of our brethren of the other liberal professions. This, indeed, is right, for no man, the priest possibly excepted, enters into such intimate relations with his people. He is ever present with them to share their sorrows and their joys, and in his position of family friend and family confessor it is his place to bind and salve wounds more deadly than those made by the hand of man. It is a popular impression that this close relationship between the physician and his people is one evolved by the brain of the novelist or one possessed by that most beloved, but now extinct, old family physician. Let us get this impression from our minds and let us realize that our duties, our responsibilities and our relationship to those we serve are just the same, are just as close, and are just as engrossing as they were when that dear old patriarch of the profession made his rounds, scolding some, chiding others and advising all to better, purer and nobler lives. Changed as our relationship to the community may be in some respects

by the translation of many of the brightest and best of our cult into the ranks of the specialist, it is still and always will be the general practitioner who is looked up to as "the physician," and by his work in professional and private life our profession will be judged.

In the beginning of my paper I stated I could do little more than rehearse to you some of the old axioms and maxims that have been handed down to us for generations. I am aware that I have taught you nothing new tonight, and that I have not tapped that fountain of inspiration from which genius gushes in poetic or oratorical streams. I trust I may have convinced you that it is not amiss for us at times to hold close communion with our souls, and to take stock of our moral and professional assets. The further I have advanced the more fully I have realized how impossible it is to evolve new ideas or elaborate new creeds to supersede those by which the fathers lived and died and earned honor for themselves and our profession.

So we face today, gentlemen, just about the same propositions that have always been ours to meet, and what was ethical one hundred years ago is ethical now.

The science of human duty simply demands that you be honest to yourselves, honest to those you serve; that you may look every man squarely in the face and not as if you feared he had heard something you had said behind his back. May I quote to you the words of the Earl of St. Vincent to the immortal Nelson: "It is given to us all to deserve success; mortals cannot command it."

THE STUDY OF RECTAL SURGERY IN NEW YORK CITY.

By J. Dawson Reeder, M. D.,

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Having decided to take a course in Rectal Surgery, I arrived in New York and matriculated at the New York Polyclinic Hospital on October 1st for a course of instructions under Prof. James P. Tuttle, and desire to herewith describe briefly my reception:

Professor Tuttle is a finished surgeon of the old school of gentlemen, a master of his art, and, under all conditions and circumstances, adheres strictly to the ethics of the profession. I was not only most cordially received by him socially, but was most fortunate in being honored by requesting me to assist him, or be present, on operations upon his private patients at an uptown hospital. This unexpected and friendly honor gave me an opportunity to observe closely the work of this great surgeon in detail, and I had the pleasure of witnessing every case under his care during my three months' visit. As to his collossal work on cancer of the rectum and sigmoid, his results are too well known for me to dwell upon at this time, and he has an enviable record which makes him the authority of this distressing malady which is so prevalent in the cases referred to the Rectal surgeon, and have so long been unrecognized by the general profession. I had the pleasure of witnessing him extirpate the rectum by his bone-flap and perineal route, and in some of these cases was honored by being his assistant. As to the method and technique in each of the above mentioned, I will endeavor to give later. Another very important point gained by association with this surgeon was, that my own theory as to the merits of the Whitehead operation were simply an endorsement of his teachings, namely, that this particular operation, while classical, was only justifiable in selected cases of hemorrhoids, while the Clamp and Cautery or the Ligature method had no restrictions as to variety or location of the pile mass.

Another important subject was the question of treatment of Tubercular fistula. For a number of years Dr. Tuttle said he was most discouraged in his results and had almost abandoned any attempt to cure this class of infections, but of late he had obtained most excellent results by introducing his soft flexible probe and following this tract with a grooved director; opening this throughout its entire extent, and then completely cauterizing at dull red heat with the actual cautery. This is then packed with iodoform gauze, and since using the cautery, his results have been decidedly better. Under the direction of his assistant, Dr. J. M. Lynch, a class of three was formed, with regular work and instructions in the dispensary of St. Bartholomew's Clinic, where we were given cases to diagnose and treat. This course consisted in introduction of proctoscope and sigmoidscope diagnosis of ulcerations specific and benign, and local treatment through this instrument. To the inexperienced the results and probabilities gained through the use of

this pneumatic instrument of Tuttle's, which is a modification of the Laws proctoscope, are surprising. By the electric illumination with which it is equipped one is able to introduce the instrument with absolute safety to the patient for a distance of 10 to 14 inches, exploring the entire circumference from the anus up through the sigmoid.

My next course of instructions was under the direction of Prof. Samuel Gant at the New York Post-Graduate Medical School. Dr. Gant likewise was most cordial in his reception, and on several occasions honored me by entertainments, including letters of membership to his club, and at his home with his family. Dr. Gant, also a master of his art, has made a reputation of renown, and is a most successful operator. While of an entirely different character from that of Dr. Tuttle he is equally attractive. Dr. Gant argues that the majority of cases of cancer when seen by the specialist are too far advanced to offer any hope by radical operation, and generally limits his attempts at relief to a colostomy. As to the merits of this procedure, I am not sufficiently versed to offer criticism further than to say that the results of Dr. Tuttle are certainly encouraging to the surgeon who will undertake this ordeal of extirpation in hopes of eradicating the disease, while Dr. Gant's operation of colostomy, of course, is only palliative, he making no claims of a cure, except when the growth is seen very early and is freely movable; then he will extirpate.

As to the operation for hemorrhoids, Dr. Gant uses ligature and sterile water anesthesia in nearly every case, and the patient is thereby cured without the administration of a general anesthetic. The difference in the time of recovery is a question to be always considered, in my own judgment, and is as follows: Dr. Tuttle uses the clamp and cautery almost universally, and the patient is discharged within the period of one week, while the ligature method requires local treatments to the ulcerations produced by the sluffing of the linen threads, and takes from 10 days to three weeks.

Constipation and Obstipation are treated surgically by both of these gentlemen by the operation of Sigmoidopexy or Colopexy, which consists in anchoring the gut to the abdominal parietes after having first stripped back the peritoneum over the area covered by their sutures.

Chronic diarrheas and Amebic Dysentery are likewise treated by Appendicostomy and Caecostomy. The difference in this operation being that the former consists in delivering the appendix upon the abdomen and fixing the same with catgut sutures until the peritoneal cavity is walled off by adhesions, and then amputating later, so that the stump may be dilated to permit of regular colonic irrigations.

Dr. Gant performs a similar operation, to which he has applied the name of Caecostomy, and having devised an ingenious director consisting of one metal rod within a tube of slightly larger calibre, he is able to pass the obturator through the ileo-caecal valve, and then, by withdrawing the rod or obturator, is able to pass a rubber catheter into the small intestine. The metal tube is then withdrawn and a shorter catheter is placed parallel with the long one, which necessarily is in the caput, and after placing clips upon each tube to prevent leakage, he is able to flush out both large and small bowel at desired intervals.

As to the irrigations through these newly-made openings, it is a matter of choice with different operators, those in greatest favor, I think, being Ice Water, Aq. Ext Krameria and Quinine Solution.

A very interesting case brought before us by Dr. Tuttle was one of Specific Stricture of the Rectum, and the treatment anticipated is as follows: He performed a Maydl-Reclus Colostomy in the transverse colon, in order first to treat the ulcerations and infected area locally, and, secondly, so that he would have sufficient gut above the stricture to do a Perineal extirpation later and bring down new healthy intestine from the upper Sigmoid for a new permanent anus; then later he would close the artificial anus in the transverse colon, and his patient should have a perfect result. The period required for these three operations would cover a period of not less than nine months; and if after this there is not perfect Sphincteric action, Dr. Tuttle does a plastic operation to repair his sphincter.

Before continuing with a brief description of the technique of Extirpation as above referred to, I wish to herewith express my sincere gratitude and appreciation of the many honors and courtesies extended to me by these gentlemen, and am quite sure that the same was not all personal, but honor to the University of Maryland's

Faculty of Physic, who have aided so materially this younger specialty by such men as Hemmeter, Pennington and Earle, who are constantly quoted by all intestinal and rectal surgeons.

EXTIRPATION OF RECTUM.

The operation of removing the rectum is now almost two centuries old. Faget performed it in 1739, but Listfrane first successfully extirpated the rectum for cancer in 1826. The results of the operation in nine cases were embodied in a thesis by one of his students (Penault, Thesis, Paris, 1829), and in 1833 the great surgeon himself gave to the world a complete account of his operation and method, thus establishing the procedure as a surgical measure. The results in these cases were not calculated to create any great enthusiasm, for the mortality was high owing to the lack of aseptic technique. The methods described in older books give us five varieties of operation for extirpation — the perineal, the sacral, the vaginal, the abdominal and the combined. In this paper I shall only endeavor to describe briefly the two methods used by Dr. Tuttle. Before describing these methods in detail it may be well to consider the preparation of the patient, which is practically the same in each. In order to obtain the best results, it is necessary to increase the patient's strength as far as possible by forced feeding for a time, to empty the intestinal tract of all hard and putrifying faecal masses, to establish as far as we may intestinal antisepsis and to check, in a measure, the purulent secretion from the growth. It requires from 7 to 10 days, or longer, to properly prepare a patient for this operation. The diet best calculated to obtain a proper condition of the intestinal tract is generally conceded to be a nitrogenous one. The absolute milk diet is not so satisfactory as a mixed diet composed of meat, strong broth, milk and a small quantity of bread and refined cereals. The patient should be fed at frequent intervals, and as much as he can digest. Along with this forced feeding one should administer daily a saline laxative which will produce two or three thin movements, and to disinfect the intestinal canal one should give through the stomach three or four times a day sulphocarbolate of zinc, grs. iiss., in form of an enteric pill. On the day previous to the operation the perinaeum, sacral region and pubis should be shaved, dressed with a soap poultice for two hours, then washed and dressed with bichloride dressing, which should be retained until patient is anesthetized. Notwithstanding all of these preparations, it is impossible to obtain absolute asepsis of the affected area, and so many fatalities occur from infection that it is deemed wise by many surgeons to make an artificial inguinal anus as a preliminary procedure in all extirpations of the rectum.

PERINEAL METHOD.

Under this method may be included certain operations for small epitheliomas low down in the rectum done through the anus. The patient having been properly prepared, the sphincter is thoroughly dilated; a circular incision through the entire wall of the gut is made, and the segment is caught with traction forceps and dragged by an assistant while the operator frees, by scissors and blunt dissection, to a point at least one-half inch above the cancer. The free end of the gut is then tied with strong tape, as the temptation is very great to put your finger in the bowel as a guide, and thereby invite infection. A deep dorsal incision is then made, going down to the right of the coccyx through the post-rectal tissue. The hand is then placed in the sacral fossa and the structures lifted out into the pelvis, after which this space is thoroughly packed with gauze to control the bleeding and hold the structures out of the fossa. The edges of the wound, including each half of the sphincter which has been cut posteriorly, are held by flat retractors, while the operator proceeds to dissect the anterior portion of the rectum loose from its attachments. A sound should be held in the urethra in men and an assistant's finger in the vagina in women to prevent wounding these organs. After the gut has been dissected out well above the tumor, it is caught by clamps and cut off below these. Bleeding is controlled by ligatures and equal parts of hot water and alcohol. This newly-exposed gut is then sterilized by pure carbolic acid and alcohol, or may be seared with cautery. Sometimes the peritoneum can be stripped off from the rectum and its cavity need not be opened; it is better, however, to open the cavity at once when the growth extends above this point. The peritoneum is incised, cut loose from its attachments close to the rectum, back to the mesorectum, which should be cut close to the sacrum, in order to avoid the inferior mesenteric artery. When the gut has been loosened sufficiently above the tumor, it may be still fastened

by two lateral peritoneal reflections, which are the lateral rectal ligaments, and should be cut at once. The gut is then brought down and sutured to the anus, and the operator should proceed to close the peritoneum and restore the planes of the pelvic floor down to the levator ani by fine catgut sutures. After this has been accomplished, the anus, which is now well outside the operative field, should be reopened, the gauze removed, and the gut flushed with a solution of bichloride or peroxide of hydrogen. Quenu advises that in amputating each layer should be cut separately, in order to avoid hemorrhage, but there appears to be no advantage in this; in fact, we are more likely to meet with deficient blood supply, causing subsequent sloughing of the gut, than with hemorrhage. The posterior and anterior portions of the perineal wound are packed with gauze and left open to assure drainage, and the parts are covered with aseptic pads, held in position by a well-fitting "T" bandage. A large drainage tube is passed well up into the rectum, its lower end extending outside of the dressings, in order to convey the discharges and gases beyond the operative wound.

TUTTLE'S BONE FLAP OPERATION.

"The Kraske Operation" is applied to various methods in which access to the rectum is obtained by removing the coccyx or cutting off certain portions of the lower end of the sacrum. They are all modifications of Kraske's original method, with which we are all familiar. Dr. Tuttle has modified this plan, as it furnishes a rapid and adequate approach to the rectum; it facilitates the control of hemorrhage and restores the bony floor of pelvis and attachment of the anal muscles, and involves injury of the sacral nerves and lateral sacral arteries on one side only. The technique which he employs is as follows:

The patient is previously prepared as heretofore described, and an artificial anus established or not, as the conditions indicate; before the final scrubbing the sphincter should be dilated and the rectum irrigated with bichloride 1-2000 or hydrogen peroxide. It should then be packed with absorbent gauze, so that the finger cannot be introduced. The patient is then placed in the prone position on the left side, with the hips elevated on a hard pillow or sandbag; an oblique incision is made from the level of the third foramen on right side of sacrum down to the tip of the coccyx, and extending half-way between this point and the posterior margin of the anus.

This incision should be made boldly with one stroke through the skin, muscles and ligaments into the cellular tissue posterior to the rectum; the rectum is then rapidly separated by the fingers from the sacrum, and the space thus formed and the wound should be firmly packed with sterile gauze. A transverse incision down to the bone is then made at a level of the 4th sacral foramen, the bone is rapidly chiseled off in this line, and the triangular flap is pulled down to the left side and held by retractor. At this point it is usually necessary to catch and tie the right lateral and middle sacral arteries. Frequently these are the only vessels that need to be tied during the entire operation, although if one cuts too far away from the sacrum, the right sciatic may be severed. The first step in the actual extirpation of the rectum consists in isolating the organ below the level of the resected sacrum, so that a ligature can be thrown around it, or a long clamp applied to control any bleeding from its walls. If the neoplasm extends above this level and it is necessary to open the peritoneal cavity to extirpate it, one should do this at once, as it will be found much easier to dissect the rectum out by following the course of the peritoneal folds. By opening the peritoneum and incising its lateral folds close to the rectum, the danger of wounding the ureters is greatly decreased and the gut is much more easily dragged down.

When the posterior peritoneal folds or mesorectum is reached, the incision should be carried as far away from the rectum, or, rather, as close to the sacrum, as possible in order to avoid wounding the superior hemorrhoids artery, and to remove all the sacral glands. The gut should be loosened and dragged down until its healthy portion easily reaches the anus or healthy segment below the growth. A strong clamp should then be placed upon the intestine about one inch above the neoplasm, but should never be placed in the area involved by it; for in so doing the friable walls may rupture and the contents of the intestine be poured out into the wound. As soon as the gut has been sufficiently liberated and dragged down, the peritoneal cavity should be cleansed by wiping with dry sterilized gauze and closed by sutures which attach the membrane to the gut. By this procedure the entire intraperitoneal part of the operation is completed

and this cavity closed before the intestine is incised. After this is done the gut should be cut across between two clamps or ligatures above the tumor, the ends being cauterized with carbolic acid and covered with rubber protective tissue. The lower segment containing the neoplasm may then be dissected from above downward in an almost bloodless manner until the lowest portion is reached. It is much more easily removed in this direction than from below upward, and there is less danger of wounding the other pelvic organs. If the neoplasm extends within one inch of the anus, it will be necessary to remove the entire lower portion of the rectum. If, however, more than one inch of perfectly healthy tissue remains below, this should always be preserved. Having removed the neoplasm, if one inch or more of healthy gut remains above anus, one should unite the proximal and distal ends either by Murphy button or end-to-end suture.

All oozing is checked by hot compresses, and the concavity of the sacrum is packed with a large mass of sterilized gauze, the end of which protrudes from the lower angle of the wound. This serves to check the oozing, and also furnishes a support to the bone-flap after it has been restored to position. Finally the flap is fastened in its original position by silk-worm gut sutures, which pass deeply through the skin and periosterum on each side of the transvere incision. Suturing the bone itself is not necessary. The lateral portion of the wound is closed by similar sutures down to the level of the sacro-coccygeal articulation; below this it is left open for drainage (Tuttle, Diseases of Rectum, Page 829—1903).

REPORT OF A CASE OF GANGRENOUS APPENDICITIS, FROM THE SERVICE OF PROF. R. WINSLOW.

By C. C. Smink, '09,
Senior Medical Student.

In selecting a case I have not taken one that is a surgical curiosity, or at all an unusual one, but I have taken this because it is just in these cases that a doubt sometimes exists as to the treatment when diagnosed, and often the condition of the appendix and surrounding peritoneum is in doubt, even if a diagnosis of trouble originating in the appendix is made.

History of Case—Patient, a boy, L. W., age 9 years, schoolboy; admitted December 26, 1908, with a diagnosis of appendicitis.

Family History—Parents well; one brother died in infancy, cause unknown; two brothers living and well; only history of any family disease is tuberculosis in one uncle; no rheumatism, syphilis, gout, haemophalia or other disease bearing on the case.

Past History—Measles at 5 years, with uneventful recovery; whooping-cough at 6, no complications; badly burned two years ago; has had "indigestion" (?) since he was 3 years old; pain but no tenderness during these attacks; treated by different physicians and got better for a time; no history of scarlet fever, influenza, pneumonia, typhoid or other disease of childhood.

Habits—A normal child.

Present Illness—On 20th of December, 1908, patient came home from church complaining of pains in the right side. This was Sunday. Next day he complained of severe pain all over abdomen, but on Tuesday these became localized in the right lower quadrant of the abdomen. Had some fever. Bowels constipated. No nausea or vomiting. There was a localized tenderness in the right lower quadrant from the start. Pains got better on Friday, but temperature and pulse still stayed up, and patient came into hospital on Saturday, December 26. The unusual feature was that there was no nausea or vomiting. It is also to be noted that the pain subsided suddenly on the 24th. The child entered hospital on the 26th, and on entrance the whole right side was rigid, while the left side was comparatively soft. A lump could be felt in the appendical region, the centre of which was above McBurney's point. Temperature was 99 and pulse 78. The leucocyte count, however, was 30.200; urine negative.

Child was put to bed; an ice cap placed on the abdomen. Liquid diet. The next day, December 27th, leucocytes stood at 35,200. Temperature unchanged, but the pulse had risen to 110 beats. A hypodermic of morphine and atrophine was given, and patient taken to the operating room, anesthetized, and abdomen cleaned for an aseptic (if possible) operation.

Prof. Winslow made an incision in the abdominal wall, well out toward the crest of the ilium, using the gridiron incision. The caecum was found and pulled over toward the middle line, and in looking for the appendix, which was supposed to be behind the caecum, a great quantity

of pus was found. This nasty smelling, grayish pus welled up into the wound and was sponged away. Several pieces of mucous membrane and presumably the tip of the appendix were found in the pus. Also several faecal secretions. The pus was sponged away and carefully a search was made for the appendix, or rather what remained of it. It was found tied down by adhesions and dissected loose. It broke away in pieces, and it was unnecessary to ligate any of the arteries of the meso appendix. The stump of the appendix close to the caecum was crushed, cauterized and ligated. No attempt was made to invert it, as the tissues would not stand it. The pus cavity was found to extend up behind the caecum and over toward the median line for some distance. The puncture, which I will refer to later, was then made in the right lumbar region, and two cigarette drains were introduced extending clear back into the bottom of the abscess cavity. Then a gauze drain was introduced into the anterior wound, and this sutured up. The wound was then dressed and the patient taken to the ward. Recovery from anesthetic without ill effects.

The next morning the patient was unable to pass his water, and had to be catheterized. Aside from this no ill effects were seen, and his temperature and pulse remained practically at the same place. At the end of 48 hours the drains and dressings were changed and the patient was doing well and the wound draining profusely. At no time was the bed elevated and at no time was a stimulant administered, with the exception of a hot normal salt enema on the day following the operation. Several times during his stay a dose of castor oil was given, but no other medication was necessary. As the dressings were reapplied and drains introduced daily the wounds were found to be granulating up, and gradually these closed, first the one in the lumbar region and then the one in the abdomen. By the tenth day a normal temperature was present, and he sat up on the twelfth.

The child went on to an uneventful recovery, and went home on January 21st fully cured.

This was undoubtedly one of those cases of gangrenous appendicitis where, owing either to the intensity of the infection or to a thrombosis of the vessels supplying the appendix, the vitality of the tissues is lost and gangrene results. Now, "even in this, the gravest form of appendicitis, the general peritoneal cavity is often protected against infection by walling off the pus, and the appendix, detached in the form of a slough, is often found on opening the localized abscess." But "in other cases there is from the beginning the symptoms of peritoneal sepsis and peritonitis."

Now, it seems to me that a great deal depends on the kind of infection—or, rather, the kind of organism infecting—and often the difference between a localized abscess and a general peritonitis is really the difference between a colon and a streptococcus infection. Again, should a general peritonitis develop, I have noticed from a number of cases in the wards that the prognosis practically depends on the organism, although we all know that a general peritonitis is a mighty grave condition, no matter what it is due to.

Another point in favor of the child was the fact that the gangrenous process seemed to start in the tip of the appendix, and it seems that when it starts there, there is greater likelihood of localization, and when it starts in the base a greater likelihood of general peritonitis.

I said that there was often doubt as to the condition in the abdomen in these cases. Now, there can be no doubt that the two main points in the diagnosis of a localized abscess are tumor and an aggravation of the symptoms present. But this case exemplified the fact that there may be cases where there is no aggravation of symptoms, and in a great many cases it may be impossible to feel the tumor until it has become very large, owing to its situation, viz., post caecal. Even in this case, from which a great quantity of pus was evacuated, there was no absolute certainty of finding pus on opening the abdomen, although it was suspected strongly.

I have seen a patient walk into the hospital on Sunday with a temperature of 100 and a pulse of 99, and when the abdomen was opened on Monday morning a most virulent form of general streptococcus peritonitis was found, from which the patient died the next day. It is said that it is much better to depend on the pulse and its variations than on the temperature.

I would like to call attention to several points in the treatment of this case also.

First, the place of incision was, as I said, well up towards the iliac crest, and not in the time-honored McBurney point. The wisdom of this is self-evident.

Second, the care used in not breaking up the wall of the abscess formed by the peritoneum.

Also, the fact that the appendix was carefully dissected up and tied off and allowed to heal by itself, obviating, as much as possible, the danger of a faecal fistula. The older books advised evacuating the abscess and leaving the appendix to slough off, and, while I have seen seven cases where this method was used and not a single faecal fistula, yet it seems to me the more rational treatment to remove the offender, as I have also assisted in three operations where the appendix was removed at the second operation. That is, an operation supposedly an appendectomy was done, and later, at a subsequent period, the diseased appendix was found still causing the same old trouble.

Again, the use of the lumbar puncture, so as to drain the abscess cavity from its very bottom. I wonder this is not done oftener, as it appeals to me as being a most sensible thing.

Then the abscess cavity was sponged out with gauze, and not washed out with the antiseptic fluid that books advise, thus spreading bacteria all over the peritoneal cavity, and really doing no good. Nature was allowed to throw off such things as she deemed necessary, an avenue of escape having been provided.

And, lastly, the omentum was found and brought down, covering in the cavity as much as possible, and thus aiding in the walling off process.

DIRECT LARYNGOSCOPY.

By Richard H. Johnston, M. D.

Read Before the Baltimore City Medical Society, Section on Medicine and Surgery, February, 1909.

Direct laryngoscopy, as the name implies, is the inspection of the larynx through a hollow tube without the use of a mirror. The examination is made with the patient in the sitting position, under local anesthesia, or in the prone position, under general anesthesia. To examine the larynx in the sitting position it is practically always necessary to give a hypodermic injection of morphia and atropia a half hour beforehand, to relax the muscles and to prevent excessive secretion. The patient is seated upon a low stool with the head extended and supported by an assistant. With curved forceps 20% cocaine or 25% alypin solution is quickly passed into the throat, anesthetizing pharynx, tongue and epiglottis. Jackson's slide speculum is then introduced and the base of the tongue, with the epiglottis, gently pulled forward. At this point it is usually necessary to use more cocaine directly in the larynx, which is introduced by means of special cotton carriers. In a few minutes anesthetization is complete, and the examination can be made at leisure. It will be found easier to inspect the different parts of the larynx if the head is held about halfway between the erect position and complete extension. In some patients with short, thick necks and large middle incisor teeth the slide will have to be removed from the speculum to enable one to see well. The examination in the prone position under general anesthesia is made with the patient's head over the end of the table supported by an assistant. The speculum is introduced and the base of the tongue and the epiglottis pulled upward forcibly. In this position direct laryngoscopy, even in children, is unsatisfactory, and operative procedures are well-nigh impossible on account of the muscular rigidity. The force required to lift the tissues is so great and the position of the arm is so cramped that it is difficult to get a clear view of the field. The difficulty has impressed all who have worked in this particular line. It remained for Dr. H. P. Mosher, of Boston, to discover a method of direct laryngoscopy which makes it as simple under ether anesthesia as in the sitting position. In April, 1908, he described in the *Boston Medical and Surgical Journal* the "left lateral position" for examining the larynx and the upper end of the esophagus. He designed certain instruments which I believe are too cumbersome to meet with popular favor. In Mosher's position the patient lies on the table with the head turned toward the left until the cheek almost rests on the table; the chin is flexed on the chest. In our work at the Presbyterian Hospital we have found a modified Mosher's position and Jackson's child speculum the ideal combination for the examination in the prone patient. In children the procedure is carried out with or without anesthesia. Without anesthesia the head, hands and feet are held, the chin is flexed on the chest in a normal position by placing a pillow under the head, the speculum is introduced and the larynx inspected. In adults under anesthesia the same procedure is used, and will be found much simpler than the extended position. In adults, after the speculum is in position, if the anterior part of the larynx is not seen, gentle pressure on the thyroid cartilage will bring the anterior commissure into view. Operations can be done through the tube satisfactorily. With the different methods of direct laryngoscopy it is possible to remove any growth from the larynx.

919 N. Charles Street.

ITEMS.

The Board of Trustees of the Permanent Endowment Fund of the University held its annual meeting on January 11. Judge Stockbridge was re-elected president and Mr. J. Harry Tregoe secretary-treasurer, and, with Dr. Samuel C. Chew and Judge Sams, constitute the executive committee for the year 1909. The funds and securities in hand total the gross sum of $18,635.74.

A special meeting of the Washington Branch of the General Alumni Association was held at

the office of the president, Dr. Monte Griffith, March 11, 1909, to consider the advisability of petitioning the Board of Regents to establish a Board of Alumni Counsellors, a paid president and a Board of Trustees, independent of the teaching faculties. Resolutions in favor of these measures were adopted.

Dr. Louis W. Knight, class of 1866, of Baltimore, has presented to Loyola College a valuable collection of papal medals.

Drs. H. O. and J. N. Reik have removed their offices to 506 Cathedral street.

Drs. W. D. Scott and W. E. Wiegand attended the banquet of the Virginia Military Institute Alumni Association of Baltimore, held at the New Howard House, March 2, 1909. Dr. W. D. Scott responded to the toast "The Younger Generation and the Splendid Work of the Virginia Military Institute Today."

Major William F. Lewis, class of 1893, U. S. A. Medical Corps, has been relieved from duty at Fort Thomas and ordered to sail on June 5, 1909, for the Philippine Islands, via San Francisco, for duty.

Dr. Hugh A. Maughlin, class of 1864, of 121 North Broadway, an official in the United States Custom Service, who was assistant surgeon in the Sixth Maryland Regiment during the Civil War, is dangerously ill of pleurisy at his home. Dr. Maughlin is a member of Wilson Post, G. A. R.

Dr. James A. Nydegger, class of 1892, past assistant surgeon, United States Public Health and Marine Hospital Service, has been promoted to the rank of surgeon.

Dr. Eugene H. Mullan, class of 1903, assistant surgeon, United States Public Health and Marine Hospital Service, has been commissioned a past assistant surgeon, to rank as such from February 2, 1909.

Dr. Samuel T. Earle, Jr., of Baltimore, Md., records the case of Mrs. F. H. D., who, the latter part of August, 1907, while eating ham, swallowed a plate with two false teeth. Ten days later she had a violent attack of pain in the abdomen, followed by a chill and fever. There was no recurrence of this for one and a half months. Since then they have recurred from time to time, but not as severe, nor have they been attended with chill and fever. A diagram taken of the lower abdominal and pelvic regions showed the plate in the sigmoid flexure of the colon, on a level with the promontory of the sacrum. Examination through the sigmoidoscope brought it into view at the point shown by the X-ray. There was considerable tenesmus, and the passage of a good deal of mucous, also a tendency to constipation. Under the influence of two hypodermics of morphine, gr. 1-4, hyoscine hydrobromate, gr. gr. L-100, and cactina, which produced satisfactory anesthesia, Dr. Earle was able to grasp the plate through the sigmoidoscope with a pair of long alligator forceps, and withdraw it immediately behind the sigmoidoscope.

At the Conference on Medical Legislation, held in Washington, D. C., January 18-20, 1909, resolutions were adopted providing for a committee composed of one member each from the medical departments of the Army and the Navy, one from the Public Health and Marine Hospital Service, one member from the District of Columbia and one member from the Council on Medical Legislation, to present to the medical profession the conditions under which the widow of Major James Carroll is now placed, and to devise such plans as might seem advisable for her relief. The following committee was appointed: Major M. W. Ireland, U. S. A.; Surgeon W. H. Bell, U. S. N.; Dr. John F. Anderson, U. S. Public Health and Marine Hospital Service; Dr. John D. Thomas, Washington, D. C., and Dr. A. S. Von Mansfelde, of Ashland, Nebraska.

Mrs. Carroll has been granted a pension of $125 a month on which to support herself, seven young children and the aged mother of her husband. The house, which Major Carroll had partly paid for, is mortgaged for $5,000. Since the conference adjourned the medical officers of the Army have raised enough to pay the taxes on the house, one monthly note of $50 and the overdue interest on the first mortgage, amounting to $125. Believing that the members of the medical profession will wish to contribute toward a fund for the purpose of paying the balance due on the house, the committee requests contributions of any amount. They may be sent to Major M. W. Ireland, United States Army, Washington, D. C. The editors of THE BULLETIN sincerely hope our alumni will honor the memory of our most distinguished alumnus by contributing liberally to this most worthy cause.

At the last regular meeting of the University of Maryland Medical Association, held in the amphitheatre of the University Hospital, Tuesday, March 16, 1909, the program was as follows: 1, "The General Practitioner: His Relation to His Patients, to His Fellow Practitioners and to the Community in Which He Lives," Dr. Guy Steele, Cambridge, Md.; 2, "Medical Ethics," Dr. Samuel C. Chew. Dr. A. M. Shipley, the president, was in the chair, and called the meeting to order promptly at 8.30 P. M. The attendance was large and appreciative, and listened to two remarkably able addresses. Those who had the privilege and pleasure of listening to the words of wisdom and advice both of Dr. Chew

and Dr. Steele went away with a clearer conception of their duties to their professional brethren and the public.

Immediately after the adjournment of the Medical Association the Adjunct Faculty, with its president, Dr. Joseph W. Holland, in the chair, held a very important meeting, the gist of which is as follows: Resolved by the Adjunct Faculty of the Medical Department of the University of Maryland that the Board of Regents be implored to effect such changes in the charter as to make possible the election of a president with a fixed salary, and with the duties usually associated with that office in standard universities, and a Board of Administrators independent of teaching faculties. The Adjunct Faculty also endorsed tentative plans looking towards the formation of an advisory board of alumni counsellors.

At the meeting of the Section on Opthalmology and Otology, Thursday, March 11, 1909, at the Faculty Hall, the following of our alumni read papers: "Rodent Ulcer of the Cornea (Ulcus Rodens Mooren), with Exhibition of the Case," Dr. R. L. Randolph; "Purulent Otitis Media of Infancy and Childhood," Dr. H. O. Reik.

At the meeting of the Section on Neurology and Psychiatry, Friday, March 12, 1909, the following participated: "History and Forms of Chorea," Dr. N. M. Owensby; "Etiology of Chorea," Dr. H. D. McCarty; "Treatment of Chorea," Dr. W. S. Carswell.

The Baltimore *Star* of March 27th, 1909, has this to say concerning Prof. Randolph Winslow: "Prof. Randolph Winslow, head of the Department of Surgery of the University of Maryland, is one of the best-known lecturers and demonstrators in the East. He is a close student, and has the faculty of impressing the young men of the University with the force of and practicability of his knowledge. Professor Winslow stands high in medical and surgical circles of the country, and ranks with the best surgeons." Under the caption of the leading men of Maryland *The Star* also included a photograph of Professor Winslow. By honoring Dr. Winslow *The Star* also honors the University of Maryland, whose authorities feel a natural pride in the eminent position held by its professors.

Dr. Fitz Randolph Winslow, class of 1906, a former resident physician in the University Hospital, and a resident of Baltimore, has located at Hinton, Virginia.

The Phi Sigma Kappa Fraternity had an at-home Saturday, March 27, 1909.

About sixty members of the Theta Nu Epsilon Fraternity, University of Maryland, attended a banquet at the Belvedere recently. It was served in the main hall, and the tables, which formed a semicircle, were beautifully decorated with trailing asparagus and cut flowers. During the meal a string orchestra rendered popular selections. Dr. Arthur M. Shipley, toastmaster, introduced Mr. Frederick W. Rankin, who made the address of welcome. Mr. Rankin was followed by Dr. C. H. Richards, who responded to the toast "Past and Present;" Dr. W. D. Scott had as his subject "The Fraternity Man;" Dr. R. Dorsey Coale, "The Undergraduate;" Dr. Randolph Winslow, "The Near Doctor;" Dr. John C. Hemmeter, "Our University," and Mr. C. B. Mathews, "The Ladies." The reception committee in charge of the arrangements was as follows: Frederick W. Rankin, chairman; Ross S. McElwee; John W. Robertson, John S. Mandigo, Arthur L. Fehsenfeld, J. F. Anderson.

DEATHS.

Dr. Joseph R. Owens, class of 1859, mayor of Hyattsville, Md., and treasurer of the Maryland Agricultural College, died at his home, in Hyattsville, March 15, 1909, after a lingering illness of six months. Death came peacefully, and at the bedside were his wife, who was Miss Gertrude E. Councilman, of Worthington Valley, Baltimore county, Md.; his daughter, Mrs. Geo. B. Luckey, and his son, Charles C. Owens, of New York. Besides these he is survived by his mother, Mrs. Percilla Owens, 90 years of age; a son, Mr. L. Owens, of New York, and a daughter, Mrs. A. A. Turbeyne, of England.

Dr. Owens was born in Baltimore, February 20, 1839, and was 70 years old. His parents removed to West River when he was seven years of age. When he was ten years old he entered Newton Academy, Baltimore, and in 1859 was graduated from the Medical Department of the University of Maryland. Immediately after leaving the University he was appointed resident physician at the Baltimore City Almshouse, and served in this capacity to 1861, when he returned to Anne Arundel county and began farming on West River. In 1885 he removed to Hyattsville and accepted the position of clerk of the Claims Division of the Treasury Department, Washington. He held this office until 1890, when he was named as treasurer of the Maryland Agricultural College, which position he filled until death. For several years Dr. Owens was collector of taxes in Anne Arundel county. When the municipal government of Hyattsville was changed from a board of commissioners to a mayor and common council, Dr. Owens was elected councilman from the Third ward, and served with marked ability until May, 1906, when he was elected mayor.

He was elected for three consecutive terms without opposition, and was foremost in every move tending to the advancement of the town. As treasurer of the Maryland Agricultural College he became acquainted with many of the leading men of the State, by whom he was held in the

highest esteem. He was secretary of the Vansville Farmers' Club for many years, a director of the First National Bank of Hyattsville. Interment was in the cemetery adjoining Old St. James' Protestant Episcopal Church, near West River, Anne Arundel county. The coffin was borne from his late residence, Hill Top Lodge, by seven cadets of the Agricultural College—Cadet-Major Mayor, Captains Burrough and Jassell, Lieutenant Jarrell and Sergeants Freere, Saunders and Cole. A squad of 25 cadets, five from each class of the College, under command of Captain Gorsuch, escorted the body to Pinkey Memorial Church, where the Episcopal burial service was read by Rev. Henry Thomas, rector of St. Matthew's Parish, of which Dr. Owens had been registrar and a member of the vestry for several years. The body, preceded by the college cadets, was taken to the Chesapeake Beach Railway Station and shipped to Lyons Creek, and thence to St. James' Church. Rev. Henry Thomas officiated at the grave. The pallbearers were: Messrs. Wirt Harrison, Harry W. Dorsey, E. B. Owens, O. H. Carr, T. Sellman Hall and E. A. Fuller. A special meeting of the Mayor and Common Council was held in Heptasophs' Hall March 22, 1909, to take action upon the death of Dr. Joseph R. Owens, late Mayor of Hyattsville. Acting Mayor John Fainter Jr., was chairman and Town Clerk G. H. Carr was secretary. Former Mayor Dr. C. A. Wells eulogized the late Mayor, both as a public official and a private citizen. Dr. Joseph A. Mudd, W. P. Magruder, R. E. White, J. W. Aman and Edward Devlin, all members of the Council who served with Dr. Owens, and R. W. Wells, M. J. Smith and S. J. Kelly, the last named as members of the present Council, also made appropriate addresses. It was resolved that in the passing away of Dr. Joseph R. Owens, Mayor of Hyattsville, we have lost a conscientious official, a valued associate and a personal friend, and the citizens of Hyattsville at large, as well as his official associates, have experienced a bereavement, the effects of which they will ever feel.

Dr. Asa S. Linthicum, class of 1852, a former member of the Board of County Commissioners of Anne Arundel county, died at his home, in Jessup, Md., Sunday, March 28, 1909, from apoplexy, aged 78. About 25 years ago Dr. Linthicum retired from the active practice of medicine to engage in iron ore mining.

Dr. Linthicum's wife, who died about five years ago, was Miss Nettie Crane, of Clifton Springs, N. J. Interment was in Loudon Park Cemetery, Baltimore.

Dr. John Bailey Mullins, class of 1887, of Washington, D. C., a member of the American Medical Association and the American Society of Laryngocology and Otology, formerly of Norfolk, Va., died at his home, in Washington, D. C., from cerebral hemorrhage, February 11, 1909, aged 42.

Resolutions on the death of Dr. John Bailey Mullins:

WHEREAS, It has been God's purpose to suddenly call hence one of our most useful and beloved members; be it

Resolved, By the Washington Branch of the General Alumni Association of the University of Maryland, that we are deeply grieved by the premature death of our honored associate. By his death the public, especially those worthy of charity, whom he was ever ready to serve, have lost a most useful citizen, the medical profession a skilled and painstaking physician and surgeon, and the University of Maryland an able and active worker. And be it further

Resolved, That the sympathy of this Association be extended to his daughter, whom he loved before all else on earth, and to whom he was ever a dutiful father. And be it further

Resolved, That these resolutions be spread upon the minutes of our Association and a copy of the same be sent to the parent Alumni Association in Baltimore.

Committee—I. S. Stone, William L. Robbins, Harry Hurtt. Monte Griffith, president; W. M. Simpkins, secretary.

Dr. Samuel Groome Fisher, class of 1854, of Port Deposit, Md., died at the home of his son, in Port Deposit, February 22, 1909, aged 77. For more than 50 years Dr. Fisher was a practitioner of Chestertown, Md.

Dr. Charles Brewer, class of 1855, of Vineland, N. J., died at his home, in Vineland, March 3, 1909, aged 76. From 1858 to the outbreak of the Civil War he was a member of the Medical Corps of the Army, and during the war a surgeon in the Confederate States service. Under President Cleveland he was postmaster at Vineland, N. J., and resident physician at the State Prison, Trenton, from 1891 to 1896.

Dr. William F. Chenault, class of 1888, of Cleveland, N. C., a member of the Medical Society of the State of North Carolina, died at his home, in Cleveland, N. C., February 24, 1909, from cerebral hemorrhage, aged 46.

Dr. James B. R. Purnell, class of 1850, of Snow Hill, Maryland, died at his home, in Snow Hill, March 7, 1909, from senile debility, aged 80. He was vice-president of the Medical and Chirurgical Faculty of Maryland in 1900-1901, formerly physician to the county almshouse and health officer of Worcester county.

Dr. Benjamin Franklin Laughlin, class of 1904, of Kingwood, West Virginia, died at the home of his father, in Deer Park, Md., from paralysis, March 9, 1909, aged 31.

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THREE ESOPHAGEAL CASES.

By RICHARD H. JOHNSTON, M. D.,

Lecturer on Laryngology in the University of Maryland, Surgeon to the Presbyterian Hospital, Baltimore.

The esophagoscope has passed the experimental stage in the diagnosis and treatment of esophageal lesions. Its usefulness has been demonstrated so often that it would seem superfluous to dilate upon its value. Its use, however, is not as general as it should be. There are still those who consider esophagoscopy unnecessary or impracticable. At the Presbyterian Hospital we have had numerous instances of its practicability, and with us it has become the routine practice to examine all patients complaining of obscure esophageal symptoms. Dr. Chevalier Jackson records the case of a patient whose only symptom was a lump on swallowing. She appeared to be a neurasthenic, and his advice to have the esophagus examined was ignored by the family physician. Two months later, with the patient etherized for a radical antrum operation, he passed the esophagoscope and found a malignant growth.

Three interesting cases have recently come under my observation, and they illustrate so well the value of the esophagoscope I shall report them somewhat in detail. The first patient was seen with Dr. E. B. Freeman; she was 67 years old. The morning before she came to the hospital, while eating ham, she swallowed a large piece that had not been sufficiently masticated. It lodged in the introitus esophagi and remained there. When she came to the hospital she had swallowed neither solid nor liquid food for nearly thirty-six hours. A half hour before examining the esophagus she was given a hypodermic of morphia and atropia. With the patient in the sitting position the throat and upper end of the esophagus were anesthetized with 10 per cent. solution of cocaine. Jackson's laryngeal speculum was introduced and the larynx pulled forward. A large mass resembling somewhat an ulcerative epithelioma was seen, and proved to be the piece of ham. Dr. Freeman and I removed it piecemeal with Pfau's foreign body forceps. It required about forty-five minutes to remove it entirely. The patient stood the ordeal well, and was able to go home the same afternoon. For about a week she had temperature, cough and expectoration, but ultimately made a good recovery. In this case the esophagoscope probably saved the patient an esophagotomy. The second patient was a female, thirty-three years old, referred to me by Dr. J. F. Chisolm, of Savannah. While at an oyster supper she attempted to swallow a large oyster, with the result that she choked for a few seconds and then had a sense of fulness in the region of the larynx. The next day she had some difficulty in swallowing, so that she took only liquids. The second day afterward swallowing was decidedly painful; she grew rapidly worse, until the fourth day her condition was serious. She reached this city the morning of the fifth day, with a temperature of 100 degrees and extreme prostration. The examination of the esophagus was made under ether with the head in the extended position. No foreign body was found, but the upper end of the esophagus was red, swollen and edematous, and seemed to be closed. The patient was given cold milk and ice bags to the throat. For two days she suffered excruciating pain on swallowing, and it looked as if we would have to resort to rectal feeding. The next day there was slight amelioration of the pain, which gradually disappeared. In this case the esophagoscope enabled us to see at once that a foreign body was not present, and that the symptoms were due to a severe, acute inflammation, probably caused by a piece of shell attached to the oyster.

I was asked by Dr. A. M. Shipley to examine a patient who had been referred to him for probable cancer of the stomach. The man was sixty years old and had had some trouble in swallowing for about two months. Attempts to pass the

stomach tube were unsuccessful. The patient was examined in the sitting position after cocaine anesthetization. No difficulty was experienced in passing the esophagoscope. About three inches below the cricoid cartilage the progress of the instrument was arrested by a tumor partially closing the esophageal lumen. The esophagoscope showed that the tumor was too low for removal. In this case the patient can be dilated through the esophagoscope and made more comfortable for the short time he has to live.

919 North Charles street.

SYPHILITIC OSTEO-PERIOSTITIS.

By C. G. Moore, '09.
Senior Medical Student.

The bony manifestations of syphilis occur as secondary and tertiary lesions, and as Keyes, of New York, has pointed out, these so-called "nodes" are simply local periosteal congestions, accompanied by serious effusions without cell hyperplesia. Any bone in the body may be affected by syphilis, but certain of them suffer by preference, such as the thin bones of the nose and pharynx—that is, those exposed to climatic changes and injuries, such as the bones of the skull, ulna, tibia, etc.

We must call special attention to injury as a powerful pre-disposing cause of bone syphilis, for, when we consider that bone lesions may be the only manifestations of existing syphilis, with the presence of a bone lesion before us, with an antecedent history of an injury, we must not forget that we may overlook the true nature of the disease, and hence must be constantly on the alert for the syphilitic taint.

Lancereaux classified the bone lesions under three heads, viz.:

(a) Inflammatory osteo-periostitis.

(b) Gummy tumor of bone.

(c) Dry caries, atrophic form.

(1) Inflammatory osteo-periostitis is the most frequent form, and is characterized by inflammatory phenomena, vascularization and exudation of a serio-glutinous material. It may be either diffuse or circumscribed, and located, as its name implies, in the area of contact with the osseous and periosteal surfaces. The pain is aching, acute, throbbing or boring in character, while tenderness upon pressure and percussion is most exquisitely excruciating. The diagnosis of inflammatory osteo-periostitis is comparatively easy, if we remember the characteristics, viz., an oval, painful, boggy or even hard bony lesion, accompanied by nocturnal exacerbations of pain, with a concomitant or antecedent history of syphilis. Ostitis with parenchymatous thickening is somewhat less positive in its character, but with nocturnal pains which are usually constant.

(2) Gummy tumor of bone develops either under the periostum, in the substance of bone, or in the medullary canal. It is simply an intensification of the process found in the inflammatory form just described, the difference being that the cell hyperplasia is more abundant. Much of the new material collects in a circumscribed space, and being more rapidly formed and less capable of organization, it entails more profound lesions by its retrograde metamorphosis. Generally tumor of the bone is, therefore, a much more serious form of disease than osteo-periostitis.

In the long bones the medullary canal is the usual seat of deposit. The bone becomes hypertrophied in a porous manner, the Haversian canals and canaliculi become enlarged and filled with a gummy material which resembles a solution of gum arabic. In the flat bones, especially the cranial bones, the cancellar tissue is attacked, and may cause a separation of the two tables, and often necrosis of one or the other plates results. If it happens to be the inner one which undergoes carious degeneration, brain symptoms will develop.

(3) Dry Caries.—According to Virchow, dry caries is always due to syphilis. This affection is a miniature gummy ostitis. Around one of the vascular canals the gummy material is deposited, this gummy material being later absorbed, leaving a stellate induration. This goes on leaving a a funnel-shaped depression, its point leading into the diploe, which may be plainly appreciated by palpation. The essential features of this caries is the fact that no sequestra are formed, no pus extruded, nor is the skin but rarely involved.

The following is a case of syphilis in which osteo-periostitis developed:

On January 22nd, 1909, R. B., age 35, white, a housewife, applied to the Medical Department of the University Hospital Dispensary for treatment, complaining of rheumatism in her back and a sore shin. The patient has been married 14 years and has had four children; the two eldest are the only ones now living. Three years ago she gave birth to a full-term child which only lived a few minutes after expulsion.

One year later she gave birth to another child, which was not at full term, but about six months advanced. She says two days previous to this birth she fell down stairs and struck on her abdomen. When the child was born its thigh was fractured, and the physician who attended her said the fracture was caused by the fall.

Her father died nine years ago, at the age of 68 years, of apoplexy; her mother was killed a few years ago in an accident. She has two brothers and three sisters, all living and in good health, as far as she knows. She is at present living with her husband, and says he is apparently well and sound, but drinks heavily, and when under the influence of liquor abuses her a great deal. Patient denies ever having had tuberculosis, syphilis, diphtheria, typhoid, scarlet fever, malaria, grippe, gonorrhoea, or any of the nervous or malignant diseases. She sometimes has a sore throat when she takes cold, but it only lasts a few days. She has complained of rheumatism in her back and limbs for the past three or four years, and thinks it is worse at night.

Patient never complained of any trouble other than those mentioned until three years ago, when her third child was born. She says that at that time her hair fell out, and an eruption, which itched slightly, broke out all over her body, including her face, but only extended down her arms as far as her wrists. This lasted a few weeks, then seemed to subside, but never entirely disappeared, and when she gave birth to the still-born child, one year later, it broke out again worse than before. She went to Dr. McElfresh, who treated her for about three weeks, giving her some medicine to take internally, also some sulphur ointment. She for a time got some better, but owing to her circumstances was unable to continue treatment with Dr. McElfresh, and has done nothing for her condition until the present time. For the past four months she has been suffering with a pain in her right shin; this has been gradually getting worse, and one week ago began to swell and cause her considerable pain, being worse at night, and sometimes hurting her so much that she is unable to sleep, hence her reason for coming to the dispensary.

Upon questioning her in regard to her general health, she says she feels as well as she ever did, with the exception of the previously mentioned pain.

Her appetite and digestion are good, and her bowels are regular, and she has no lung, heart or kidney trouble. She has had no headaches, nausea, or vomiting, and her menstrual periods have always been regular and painless.

Upon examining patient I found her to be well nourished and well developed, weighing 142 pounds. Her color was good and her pupils about normal in size, reacting to light and accommodation. Both patella reflexes were absent, also Romberg's sign, and there was no enlargement of the mastoid, epitrochlear, post-cervical or inguinal glands. Her pulse was 84 to the minute, regular in rate and force. The tension and volume was good; her temperature was 98.6°. Her heart was normal in size, and on auscultation the sounds were clear and no murmurs were heard. The expansion of both lungs was good, the respirations being 20 to the minute.

Percussion and auscultation were negative; all the abdominal organs seemed to be normal. There was an ecchymotic area under her left eye, which she says was caused by her husband striking her two years ago when intoxicated.

There was a circular reddish macular papular, non-itching eruption which does not disappear on pressure, varying from the size of a bird shot to that of a nickel, and is confined to her back, chest, shoulders and arms, most profuse on the left side, and is not seen on the lower limbs at all. On her left shoulder some of these lesions have developed into pustules, which have become infected and slightly ulcerated; these give her slight pain.

In the corner of her mouth is a scar which looks like the initial sign of lues, but she claims it appeared a few weeks after the breaking out on her body. On examining her mouth no mucus patches or scars were found.

She now has an osteo-periostitis on the anterior aspect of her right tibia. It is moderately swollen, slightly reddened, and is very painful (the pain is aching, acute and boring in character) on pressure, and on tapping the bone with my finger above and below this point it caused her intense pain. (Patient claims she has never received any injury in this location.)

Upon consulting Dr. McElfresh, he remembered the case and said that he had treated her for a short time about two years ago for the initial symptoms of syphilis, but since then has never seen her.

She is now receiving the mixed treatment of protiodid of mercury, gr. ¼, with a saturated solution of potassium iodid three times a day, starting her on ten drops, then increasing it one drop each time taken. I requested her to return when the medicine is finished.

DISCUSSION BY DR. WARNER HOLT, OF WASHINGTON, OF THE PAPER ON THE CHEMICAL CO-RELATION BETWEEN THE SALIVARY GLANDS AND THE STOMACH, BY JOHN C. HEMMETER, OF BALTIMORE.

Read Before the Society for Experimental Biology and Medicine, of New York, Meeting in the Rockefeller Institute for Medical Research, on December 16, 1908.

Dr. Holt said in part: "This experimental study by Dr. Hemmeter is not, as it might appear to be, only an inquiry into the physiology of a limited part of the digestive apparatus, but it is an attempt to solve a biologic problem and to get at the broad basic principles that underlie the chemical co-relation of the organs.

"When a worker occupies himself with the effect of the extirpation of one organ of digestion upon the organs in the next segment of the digestive apparatus, he naturally thinks of phenomena of exclusion or loss of function in one or the other of the segments following the one extirpated, but instead of phenomena of exclusion it is conceivable that those of exaggerated activity in the other segments of the digestive tube might result.

"For '*a priori*' we cannot know whether the influence that one segment of the digestive tract exerts upon the succeeding segment is that of stimulation or of inhibition, or of both, viz., of stimulation under one set of conditions and inhibition under another set of conditions. In the investigation of the problem of a chemical co-relation between the salivary glands and the stomach, Dr. Hemmeter has done meritorious work, a great part of which it has been my good fortune to observe and assist in personally; though I am a physician in the employment of the government at Washington, I consider myself a post-graduate student of Professor Hemmeter. I have seen personally four of his animals that had successfully been nursed through the Pawlow operation and extirpation of the salivary glands after months of the most trying work. It required a great deal of perseverance to persist in this kind of work, especially when some of the best animals that had emerged safely from the vicissitudes of the operation for an accessory stomach and from the removal of all the salivary glands on one side of the head succumbed to the third operation in the attempt to remove the remaining salivary glands on the other side.

"The history of these operative failures, though they will never be told, constitute a large part of the merit of those who have worked with Dr. Hemmeter in this research. No matter what the final outcome of the future investigation of this problem will be, whether affirmative or negative, the intrinsic value of such work will be appreciated by all who are to the least degree conversant with the history of physiology. Nowadays we are too liable to forget the hard plodders in experimental work who have started the solution of a problem, and when the last word has been said the worker of the beginning is generally forgotten.

"In this connection I desire to quote an expression of Prof. William H. Welch concerning the merit of the work of ex-Surgeon General Sternberg, done since the first Yellow Fever Commission was appointed, in 1879 (see Medical News, June 21, 1902, p. 1198). Dr. Welch said 'that Sternberg's work with yellow fever would stand forever; that it was a common thing in these busy days to forget the steps which led up to an important discovery. All that Dr. Sternberg had done in the study of yellow fever was necessary work, and it had to be done just in the way that he did it. The ground had first to be cleared. If it were not so, the discovery had not been possible; and later discoverers themselves would have had to hunt out the large host of microorganisms which Dr. Sternberg had described and laid aside.'

"And similarly I can say of Dr. Hemmeter's efforts that, no matter what the eventual outcome of this problem will be, all that he has done was necessary work, and it had to be done just in the way that he did it.

"Just one more idea and I shall have finished. It concerns the demonstration of such research work in places at a distance from the experimentor's laboratory. Such demonstrations are always attended with great difficulty. They usually require four animals, two or three janitors to transport them, and as many laboratory assistants as

the director of the laboratory can manage to take with him. The technique of these operations, the high-grade sensitiveness of operated animals, the refinement with which chemical tests should be made, all require for their safe conduct that the experimentor should work only with those men who are used to his system. The animals themselves are always influenced in one way or other by the presence of strangers. I remember in one animal which was demonstrated on March 17th, at the University Hospital, the demonstration at which Dr. Satterthwaite was present, a most unexpected change in the quality of the gastric secretions took place. This was a control animal which had undergone no operation whatever. He was simply taken along to show the proteolytic power of a normal dog and compare it with the operated dogs. His gastric juice had been previously tested on several occasions, and always found to be of regular standard, but on the night of the demonstration before the Medical Society this animal's gastric juice was practically inactive, containing no HCL nor pepsin.

"Dr. Hemmeter has already informed you that in some animals the loss of gastric juice after extirpation of the salivary glands is only temporary, and that in varying time—in some cases three weeks, in other animals three to four months—there is a gradual resumption of gastric secretion. This resumed secretion, however, never becomes as effective as it was in the same dog before an operation. The question when to begin to make observations on an operated animal depends entirely upon the state of this animal; if the dog eats his food with appetite he has no fever, and his digestion appears to be satisfactory; then the observations may be begun, even if it is only one week or ten days after the last operation. One of the most valuable animals that was used in this series of experiments was so injured in the effort to transport him to another laboratory that he could not be used for further experimentation. The dog struggled so in his holder while he was being transported in a wagon that the partition of true mucosa which separates the accessory from the plain stomach was broken through. This had happened once before in transporting a dog from the laboratory to Dr. Hemmeter's country place, and his associates in the Medical Faculty, becoming aware of the great labor and cost involved in such operations, and the rarity with which they succeed, advised that no further Pawlow dogs be sent to other laboratories."

AN INTERESTING CASE OF SCROTAL HERNIA.

By G. E. Bennett, '09.

Senior Medical Student.

Patient—George Kolubaher.

Age—Sixty-six years.

Occupation—At present a farmer; formerly worked as laborer in stone quarry.

Complaint—Patient entered the hospital on January 21, 1909, complaining of great pain and discomfort in the right inguinal region and in the scrotum of the same side.

Physical Examination—Inspection showed an enormously enlarged scrotum, more marked on the right side, and a prominent swelling along the right inguinal canal, which was most marked when standing. Marked discoloration on the skin of the scrotum and inner side of both thighs, probably due to use of counter-irritants.

Palpation—Mass soft and freely movable, showing no skin attachments; slight impulse on coughing. Slightly painful on pressure. Some gurgling when manipulated.

Percussion—Slightly tympanitic.

Remarks—Contents of the sacs were forced into abdominal cavity after prolonged manipulation, returning to original condition as soon as pressure was taken away.

History of patient shows nothing of interest except that of the present condition, which began suddenly twenty years ago. While lifting a heavy block of stone had a feeling as though something had "given away" in his right side. This sensation was immediately followed by one of intense pain and general discomfort. The day following the patient noticed a small lump in the right inguinal region that disappeared on pressure, returning when he lifted any heavy object.

For eighteen years the condition gave him no serious discomfort except for the wearing of a truss and becoming larger. Two years ago the truss was discarded as being useless.

One week ago conditions grew suddenly worse, and patient was confined to bed. Has suffered a great deal of pain and has been unable to sleep.

On January 22, 1909, patient was operated upon by Professor Winslow. Operation as follows:

Patient was brought to the operating room at 11.30 A. M., anesthetized and prepared for an aseptic operation.

Incision about five inches in length was made parallel to Pouparts ligament and immediately over the inguinal canal, passing through the skin and subcutaneous fat. The external ring having been exposed a grooved director was passed into same, passing under the aponeurosis of the external oblique muscle; fibers of same were split, using the director as a protective guide. The sac was exposed and carefully dissected free from its surrounding tissues, and upon examination was found to be continuous with the covering of the testacle (giving the appearance of a congenital hernia). The sac was next opened and found to contain small intestines and a Meckel's diverticulum. Following this the intestines were replaced in the abdominal cavity. Digital examination through the internal ring showed the bladder to be adherent to the peritoneum at the margin and toward the median line. The sac was tied close to the internal ring, cut free. The distal portions of the sac were drawn upward, bringing the testacle into view; sac was cut close to same and sutured so as to enclose the greater part of it.

The margins of the internal oblique and transversalis muscles were sutured to Poupart's ligament by a mattress suture. The aponeurosis of the external oblique was re-established into normal position by suturing, and the skin closed by subcutaneous silver wire suture silk having been used for all other sutures.

Sterile dressings were then applied and cardboard splints to keep limb immobile. Then bandaged with crenolin. The patient left the operating room at 1 P. M. in good condition.

Notes of Interest—

That a hernia, apparently congenital, should not have made an earlier appearance.

The presence of a Meckel's diverticulum in the sac, this being the condition that gives rise to a true Richter's hernia.

That a hernia of so large proportion should have caused so little trouble to the patient.

Patient recovered in very short time, leaving the hospital in good condition.

THE TEACHING OF THE SPECIALTIES.

By Hiram Woods, M. D.

Read Before the University of Maryland Medical Association, April 21, 1909.

Teaching specialties to undergraduates must be carefully separated from the same teaching to post-graduate students. The latter may be supposed to have given such thought to their future career as to have reached the conclusion that they wish to devote themselves to a certain line of work. It is not these men whom I propose to discuss, save to say, in passing, that the average six weeks' or two months' course offered by post-graduate schools is totally inadequate. As a rule such courses attract a large number of men who do little more than follow the clinical work of some well-known specialist and pick up what they can. Either prolonged hospital experience, as interne or clinical assistant, or a special *individual course,* with a competent teacher, is needed for a decent foundation in special work.

It seems to me that with undergraduate work the first important step is to secure the attention of the men, and convince them that there is something in the special course worthy of notice. There is a state of mind, not unnatural to the undergraduate, regarding specialties. Most of them propose to begin professional life as general practitioners. They think they will never have use for knowledge in the so-called specialties, and that the little they will need in order to get a passing mark can be easily crammed at the close of the session. As a matter of fact, it is easy to frame questions so that this "crammed" information is of little use, and the most liberal grading hardly ever brings such men *up* to a passing mark. The mental attitude of these men is unjust to themselves, their teacher and the patients who, in the near future, will entrust to them their physical welfare. The very term "general practitioner" implies a general knowledge of medicine. If one lives in a city, where the services of specialists are readily obtained, he may, if he desires, refuse certain cases, and take only such as he wants—say such as belong to internal medicine. But in so doing he becomes a specialist himself, and if he has neglected a properly prepared special course for undergraduates while a student he will miss information of great use to him as an internist. Many men, however, do not practice where specialists *are* easily obtained, and, perforce, *must* take cases which would logically come under one or other of the recognized specialties. Here is a professional responsibility which it is the aim and duty of a special teacher to enable his student to meet. May I illustrate by directing attention to two troubles which it is my own privilege to explain to our students? Iritis, in eye, and acute otitis

media, in ear diseases, are very common troubles. Both are, as a rule, readily diagnosed, and both offer good prognosis. Yet the responsibility for eyesight in one, and may be life in the other, may depend on the diagnostic ability and therapeutic resources of the man who *first* sees the case. Men are blind and children dead because a general practitioner has not known enough of what was offered him when a student to make a correct diagnosis. The red eye has been called conjunctivitis and treated with nitrate of silver, in spite of the absence of purulency, while the small, inactive pupil has escaped notice. The ear pain has been called "earache" without an aural examination, a hops bag and opium have been ordered, and the doctor has gone home with that false sense of security which is so dangerous. Why? If his teacher has known his business, it is not because he was not told how to look for iritis and acute inflammation of the drum, but because he had not given the subjects sufficient thought to get them drilled into his thinking apparatus. Probably he could tell the diagnostic points of iritis, if asked, or the signs of ear-drum inflammation; but this was "crammed" information, not part of his real knowledge.

If it is the duty of the student, anticipating general practice, to think about the specialties taught during his undergraduate course, it is still more the duty of his teacher to present him only such things as the general man needs. He will make a grievous blunder if he tries to make specialists of his men. His selection of subjects should be limited to the diseases which are of common occurrence, and stress should be laid on *diagnosis*. If one knows, first, what to look for, and secondly how to recognize signs and symptoms, he will generally find proper treatment. Troubles which would lead the patient to go to the specialist *primarily*, without consulting his family physician, should receive little attention.

Two other classes of lesions in such organs as are usually handed over to specialists should receive attention in the undergraduate course—those which are apt to cause remote or reflex disturbances, and those which are definitely symptomatic of central lesions. The first should, in my judgment, be dwelt upon only to such an extent as to enable the student to know causative relation and method of diagnosis. Treatment, unless very simple and easily within the reach of the medical man—i. e., the general practitioner—should be given little time. As to the second class, every neurologist knows that Tabes Dorsalis would often be diagnosed early, and proper treatment instituted, if the physician had known the meaning of association of gastric crises with Argyll-Robertson pupil, and had seen enough of these things to have them in his every-day thoughts. One could present many other illustrations, but this shows what is meant. With the student convinced of the necessity of thinking about the specialty taught, the instructor careful in selection of his subjects, a duty rests on those who fix the curriculum.

It is unfair to students to use four years for work which can be done in three. I believe that the object of the establishment of a four-year course was to furnish a year in which students, freed from the responsibility of examinations, might have time for guidance in clinical observation. The ideal plan, in my judgment, is to get rid of didactic lectures and examinations by the end of the third year, and to devote the fourth to clinical observation. Genito-urinary work, gynaecology, rhinology, neurology, ophthalmology, otology, cannot be learned from text-books or lectures, at least in such a way as to become integral parts of a man's daily thinking. And to my mind this is the only special information which will help the general practitioner in his daily work. A few hours spent in a large clinic brings more instruction than a whole year of lectures. The personal contact of man to man, the exchange of thoughts and impressions, are what sink in. A student is not to be blamed if he fails to attend these opportunities when he knows that in a few weeks he must face the ordeal of examinations on the didactic work, and that the result of these will determine his graduation. To put into a few words my idea of teaching specialties—it is the duty of the student to realize that nothing is put into the undergraduate course which is not important to *him;* it is the duty of the teacher to select only what *is* important to the general practitioner; it is the duty of the school authorities to so arrange the curriculum as to give students enough time to observe special practice personally, in small sections, so that what is taught may be so impressed by observation as to become a real factor in their medical thought.

A CASE OF SPORADIC CRETINISM.

By E. Sanborn Smith, M. D.,
Class of 1900, *Macon, Mo.*

Karl B. is the son of sturdy parents, both of whom were born and reared in the Swiss Tyrol. He had never developed like the other children—was, in fact, much smaller at five and a half years than the fourteen-months-old baby. He was dull, placid, taking no note of his surroundings, sitting or lying just where he was left, and never evinced any disposition to play or converse with the other children. I saw this child on the 4th day of January, 1908, in a purely accidental manner. The parents had been told by their attendant that the child had either rickets or was an idiot, and they in consequence had kept the child in the background for two or three years, being very much chagrined and mortified at the prospect of bearing through life the burden of hopeless idiocy. The child had such classical symptoms of cretinism that I asked permission of the family to treat him for awhile, though it required some persuasion, because of the fact that they felt it was time and money wasted. On the 5th day of January, 1908, the child was five years and a half old, twenty-eight inches in height, circumference of chest twenty-one, abdomen twenty-three. He was given one and one-half grains of thyroid extract twice daily, the dose being gradually increased until he showed signs of irritability, with accelerated pulse. The child's extremities soon warmed up, the circulation became better, the hair began to grow, the child for the first time in its life walked and talked, began to take note of surroundings and to play with the other children.

Just one year after the beginning of the treatment—January 5, 1909—the child was thirty-five and three-quarter inches in height, chest twenty-three, abdomen twenty-three.

This disease, sometimes known as cretinoid or myxoedematous idiocy, was first described by Fagg in 1871. Since then a number of cases have been published, both in England, on the Continent and in America, showing that the disease is not confined to any one country. While the disease is comparatively rare, cretins are more common than was formerly supposed. The disease seems to be in reality a pachydermatous cachexia, and it is now, I believe, well established that it is caused by congenital absence of the thyroid gland or to the presence of something which abolishes its functions. Little is known as to the causes of its destruction or abolishment of function. As a rule only one case occurs in a family, the other members presenting nothing abnormal in their mental or physical development, hence the term sporadic. It has been more frequently reported in the Tyrol, in Switzerland, a coincidence which makes this child's case all the more interesting, in that both its parents are physically and mentally well up to par and the other children possess even more than the average intelligence.

Symptoms—The symptoms are practically identical with those of the myxoedema which follows the removal of the thyroid gland in adults. The symptoms of cretinism in most cases in infants make their appearance during the first year, occasionally, however, not until the child is three or four years of age. The appearance of the cretin is very striking, and so characteristic that when once seen the disease can hardly fail to be recognized. The child is much dwarfed, the fingers and toes are short and stumpy, the cutaneous tissues seem to be thick and boggy, but do not pit on pressure, as in ordinary oedema. The facies is extremely characteristic. The head seems large for the body, the fontanel is open until the eighth or tenth year, the forehead is low and the base of the nose broad, so that the eyes seem unusually wide apart. The lips are thick, the mouth half open and the tongue protrudes slightly, the cheeks are baggy and the hair is coarse, short and straight, and the skin has the peculiar leathery feel of elephant skin. The abdomen is pendulous, large, streaked with prominent veins, and reminds one of rickets. The skin is dry, the voice husky and rough. There is but one word which describes the peculiar clumsy manner of walking—that word is waddle. The child actually waddles like a duck. The temperature is always subnormal, and one of the things the mother will always call to your attention is the fact that the child has such cold hands and feet and requires so much more cover than the other children. Cretins are dull, placid and good natured, never quarrelsome.

Treatment—There is no tendency toward spon taneous improvement. These cases have until the last few years been considered hopeless and condemned to a life of idiocy. Really, in the treatment of cretinism in the adult marvelous results have been got from the administration of

the dried and dessicated extract of the thyroid gland of the sheep. This has led to its use in the myxoedema of infancy. The results are astounding. The child grows mentally and physically, takes note of surroundings to which it formerly paid no attention whatever, and can be taught almost as well as a perfectly normal child. In all cases the thyroid extract must be kept up indefinitely, the dose being gradually increased, otherwise the improvement ceases at once.

ITEMS.

At the commencement of the University Hospital School for Nurses, held May 5th, the following nurses received their diplomas. The address to the graduates was delivered by Dr. A. M. Shipley:

Miss Elizabeth Getzendanner was the president of the class, and Miss Lucy B. Squires was the secretary.

Those who received diplomas were:

Miss Catherine Mabel Dukes, Maryland.
Miss Anna May Green, North Carolina.
Miss Laura Schley Chapline, West Virginia.
Miss Louise Dorsey Pue, Maryland.
Miss Grace Schoolfield Tull, Maryland.
Miss Annie Lou Wahm, South Carolina.
Miss Eva Sidney Chapline, West Virginia.
Miss Beulah Ophelia Hall, Georgia.
Miss Elizabeth Getzendanner, Maryland.
Miss Emily Lavinia Ely, Maryland.
Miss Lucy Bright Squires, North Carolina.
Miss Gertrude Hedwig Tews, Germany.
Miss Helen Mary Robey, Maryland.
Miss Blanche Almond, Virginia.
Miss Lillie Booker Carter, Virginia.
Miss Mary Barton Saulsbury, Maryland.
Miss Vera Wright, Maryland.

The alumni of the University will be pained to learn of the recent illness of Prof. S. C. Chew. THE BULLETIN is glad to report that he is now convalescing. No member of the Faculty is more esteemed and beloved than is Professor Chew.

Dr. Leonard O. Sloane, of Juneau, Alaska, who has been visiting Baltimore for several weeks, has left the city. He came to this city to avail himself of the opportunities for clinical instruction offered by this University, and was much pleased with the work he was able to see at the University Hospital, the Woman's Hospital, the Hebrew Hospital and at Bay View. He is physician to St. Ann's Hospital, at Juneau, and is a progressive and able member of our profession.

In the recent examinations held for commissions in the medical corps of the United States Army, Dr. J. S. Fox, one of the surgeons at the St. Francis Xavier Hospital, was a successful contestant, and the War Department has notified him that he will be commissioned a first lieutenant and will be ordered to proceed to a post in the West. One hundred doctors took the examination for the appointments, but only thirteen were successful. Dr. Fox, who will be one of the youngest surgeons in the Army, was high up in the list of the fortunate ones.

Dr. Fox is a son of the late Dr. T. S. Fox, of Batesburg, who was a distinguished surgeon in the Confederate Army. He is a nephew of Mr. J. T. Fox, of that town. Dr. Fox is twenty-nine years of age, and was born in Batesburg, S. C. After completing the high school at that place he entered Richmond College, Richmond, Va., and was there for three years, when he entered the Medical College at Baltimore. Fourteen months ago he came to Charleston to accept an appointment as one of the house surgeons of the St. Francis Xavier Infirmary, and during his stay in this city has made a fine record for himself, and now has many friends here.

As soon as his commission arrives he will leave here for Fort Sam Houston, Texas, the station designated in the orders of the War Department. There are at present several troops of the Third Cavalry and a battalion of light artillery from the Third Field Artillery Regiment stationed at this important post, which is considered to be one of the most agreeable army posts in the South. On October 1, Dr. Fox will be ordered to report to Washington, where he will be detailed to attend the Army Medical College for a period of eight months.

The Council on Pharmacy and Chemistry and the Board of Trustees of the American Medical Association have adopted a vote of thanks to Daniel Base, Ph. D., professor of analytical chemistry, Department of Medicine, University of Maryland, for his co-operation and assistance in investigating products and for special research work done at the request of the Council.

It has been definitely decided that the new operating room which is to be built at St. Joseph's Hospital is to be dedicated to the memory of Dr. Isaac Ridgeway Trimble, who died of septicemia after performing an operation upon an infected kidney at the hospital, as a result of which the patient lived. A tablet bearing Dr. Trimble's name and the incidents surrounding his martyr-like death will be placed in the operating room.

Dr. John R. Winslow read a paper on "A Case of Tuberculosis of the Fauces and Lingual Tonsils, Caused by Tuberculin Injections," before the Section on Laryngology and Rhinology, Friday, March 26, 1909. At the same meeting Dr. J. N. Reik read a paper on "The Present Status of the Surgical Treatment of Purulent Disease of the Nasal and of the Aural Cellular Spaces: a Comparison."

Dr. and Mrs. A. Duvall Atkinson, who have been spending a few days in Washington, have returned to their home, 924 North Charles street.

Under the title of leading men of Maryland, "The Star" has this to say concerning Dr. Louis McLane Tiffany:

Dr. Louis McLane Tiffany is not only one of the best-known men in Maryland, but enjoys a reputation that is international as an operating surgeon. He has performed successfully many unusual and difficult operations, and has contributed much to his profession by original research. He was born in Baltimore, October 10, 1844, and is related to the well-known McLane family of Maryland and Delaware. He received his bachelor of arts degree from Cambridge University, England, in 1866, and upon his return to Baltimore entered the University of Maryland as a medical student, his degree as doctor of medicine being conferred upon him in 1868. He soon attained prominence in his chosen work. For many years he has been professor of the principles and practice of surgery at the University of Maryland. He has been operating surgeon of many of the Baltimore hospitals, has performed operations on prominent persons all over the country, and is the author of a number of treatises on particular phases of surgery. Dr. Tiffany helped to found the Maryland Clinical Society, is a member of the Medical and Chirurgical Faculty of Maryland and an active or honorary member of many other societies.

Recently there was unveiled at St. Timothy's Church, at Catonsville, Md., a beautiful memorial window designed and executed in Favrile glass to the memory of Dr. Charles G. W. Macgill, who was president of the First National Bank of Catonsville and a physician widely known in that part of Baltimore county. This memorial, the subject of which is St. Luke, is in three panels, the figure of the evangelist being in the center opening, while a splendid landscape is carried out in the two side panels. On a scroll carried by St. Luke is the text: "For to one is given by the Spirit the gifts of healing." 1 Cor., xii: 8-9. At the base of the window is the dedicatory inscription: "In Loving Memory of Charles G. W. Macgill. Born May 10th, 1833. Died April 28th, 1907."

At the coming meeting of the American Medical Association Dr. Henry D. Fry, of Washington, will read a paper on "An Ovarian Abscess Containing a Lunbricoid Worm Within the Cavity;" H. D. Hynson, Phar. D., "The National Formulary: Its Genesis, Character and Exigent Utility."

Dr. W. L. Hart, class of 1906, first lieutenant, United States Army, has been ordered to accompany Company G, Engineers, to San Francisco, Cal., and then to return to Washington Barracks, D. C.

The following physicians have consented to act as admitting physicians, Maryland State Sanatorium: Dr. Gordon Wilson, Baltimore; Dr. Charles H. Conley, Adamstown. Dr. Guy Steele, Cambridge; Dr. Paul Jones, Snow Hill; Dr. Henry Fitzhugh, Westminster. Drs. Guy Steele and C. H. Conley are members of the Board of Managers.

Dr. A. M. Shipley, class of 1902, has been elected consulting surgeon to the Sydenham Infectious Hospital, and Dr. H. O. Reik, of 506 Cathedral street, consulting otologists.

Dr. H. E. Palmer, of Tallahassee, has been elected president of the Florida State Medical Association for the ensuing year.

The marriage of Miss Elizabeth P. Elliott, daughter of Mrs. Warren G. Elliott, to Dr. Gordon Wilson, associate professor of medicine in the University of Maryland, will take place on Saturday, June 5, 1909. The ceremony will be performed at 6 o'clock at Old St. Paul's Protestant Episcopal Church, Charles and Saratoga streets, by the rector, Rev. Arthur B. Kinsolving. Owing to mourning in the bride's family, the marriage will be a quiet affair.

Another wedding of interest to take place in June is that of Miss Lila Holmes Trenholm, daughter of Mr. Glover Holmes Trenholm, a graduate of the Training School for Nurses of the University Hospital, and granddaughter of the late Prof. Julian Chisholm, to Dr. Walton A. Hopkins, class of 1903, of Annapolis, Md.

At the annual meeting of the Cecil County Medical Society, held in Elkton, Md., April 29, 1909, Dr. C. P. Carrico, of Cherry Hill, was elected president for the ensuing year.

Dr. George H. Steuart, class of 1898, is located at Ottoman, Va.

Prof. Samuel C. Chew, the nestor of the Medical Faculty of the University of Maryland, is confined to the University Hospital with a bad attack of grip. Dr. Chew is one of the oldest and most beloved of the medical fraternity of Baltimore. He has been connected with the University of Maryland for more than fifty years, graduating with the class of 1858. All of us wish Dr. Chew a rapid restoration to his former good health.

Forty professional men were present May 1, 1909, at the Colonial Hotel, where the fourth annual reunion and banquet of the Pennsylvania Branch of the General Alumni Association of the University of Maryland was held. Dr. Eugene F. Cordell was one of the guests; others were Dr. Charles P. Noble, president of the Pennsylvania Branch, and Dr. J. C. Beale, secretary and treasurer, both of Philadelphia.

The banquet was held in the new assembly room, which was tastefully decorated with plants, flowers and the colors of the University. The banquet committee consisted of Drs. Z. C. Myers and S. K. Pfaltzgraff, of York; J. S. Classen and J. C. Beale, of Philadelphia.

It is reported that Dr. John Cox Keaton, class of 1907, of Georgia, has been shot in the abdomen by an irate husband.

At the annual meeting of the Cecil County Medical Society, held at Elkton, Dr. St. Clair Spruill spoke on "Surgical Conditions of the Right Side of the Abdomen."

The New York Medical Journal says concerning the April 13th meeting of the Philadelphia Pediatric Society: "The paper of the evening was read by Dr. Compton Riely, of Baltimore, on 'The Early Diagnosis and Treatment of Pott's Disease.'"

The following of our alumni are upon the staff of the Hospital for the Women of Maryland, John street and Lafayette avenue, Baltimore: Dr. Charles H. Riley, Dr. J. Mason Hundley, Dr. Archibald C. Harrison, Dr. Robert T. Wilson, Dr. Samuel T. Earle and Dr. George W. Dobbin. Dr. G. W. Billups, class of 1906, is resident physician.

Mr. and Mrs. William T. Schultze, of 822 Newington avenue, Baltimore, have announced the engagement of their daughter, Dr. Anna D. Schultze, a graduate of the Woman's Medical College and resident physician of the Good Samaritan Hospital, to Dr.

John R. Abercrombie, dean of the Woman's Medical College, a graduate of the University of Maryland of the class of 1895, and at present instructor in diseases of the skin, University of Maryland. No date has been fixed for the wedding.

At the coming meeting of the American Medical Association Dr. I. S. Stone, of Washington, will read a paper on "Some Minor Gynecologic Matters Which Are Often Overlooked."

Dr. Charles H. Medders, of Baltimore, who sued the Western Maryland Railroad for $5,000 for services rendered in a collision four years ago, was rendered a verdict for $150.

At the annual meeting of the Montgomery County Medical Association, held in Rockville, April 20, 1909, the following of our alumni were elected to office for the ensuing year: Vice president, Dr. Wm. L. Lewis, of Kensington; secretary-treasurer, Dr. John L. Lewis, of Bethesda.

The Baltimore City Medical Society has elected our alumni to the following offices for the ensuing year: President, Dr. Jacob Hartman; board of censors, Dr. Randolph Winslow.

Dr. G. Lane Taneyhill, of Baltimore, is a member of the House of Delegates of the American Medical Association from Maryland at the present meeting of the American Medical Association, at Atlantic City.

Dr. A. E. Ewens, of Atlantic City, was a member of the Committee on Section Meetings at the recent meeting of the American Medical Association. Dr. Daniel Jenifer also had the honor and pleasure of serving upon this committee. Dr. Jenifer was also a member of the Committee on Postoffice and Telephone. Dr. A. E. Ewens also served on the Committee on Badges.

Dr. Thomas A. R. Keech, class of 1856, and Mrs. Keech, of Washington, D. C., celebrated at their home, 416 B street, northeast, on April 13, 1909, the fiftieth anniversary of their marriage. The house was beautifully decorated with cut and potted plants. A collation was served. The family are of English descent, having emigrated and settled in Southern Maryland about 1750. Dr. Keech is a son of the late Rev. John Reeder and Susan P. Keech.

Dr. John Herbert Bates, class of 1907, of Forest Park, Baltimore, a former resident physician of Bay View Hospital, and until recently a resident physician at the Church Home and Infirmary, has located at 4002 Main avenue, Forest Park.

The third annual banquet of the General Alumni Association of the University of Maryland was held Thursday, April 22, 1909, at the Eutaw House, Baltimore. About 90 were present. The affair was a thoroughly enjoyable occasion, but more enthusiasm would have been evident if more of the members of the various faculties had been present. The Pharmaceutical Department, with less professors than the other departments, had most members present. The speeches were witty and instructive, and teemed with expressions of loyalty to the University. As oft iterated and reiterated, this body is the only real live alumni body at the University of Maryland. It has been doing since its inception, and is still doing, and if the University ever be rejuvenated much of the credit will be due to the constant agitation of this body for a larger and better university. Most alumni banquets consist of a feed, good, better or worse, as it might happen to be, and a slew of speech artists of more or less renown, who bubble over with big words of encouragement and prediction, but rest on their oars here. Indeed, the societies exist for a banquet once a year and a cyclone of hot air. What do words accomplish? Nothing. It is action that the University of Maryland needs, and more than anything else men of action—strong men, broad-minded men, men who can subordinate their success to the success of the institution, men in every sense of the word. I am glad to say the General

Alumni Association has an abundance of men of such character among its membership who are doing something for the good of the Old University, and who have an object in view. What is this object? The creating of ways and means for the betterment of the University.

At the business meeting immediately preceding the banquet the following recommendation of the special committee appointed for the purpose of formulating a plan for the participation of the alumni in the management of the University was adopted unanimously.

The plan provides that the Board of Regents of the University shall be enlarged by the addition of five members, one each from the five departments, who shall have had their degrees for 10 years or more. It provides for the election of a committee on nominations, to consist of the president of the association and one representative from each of the five departments. This committee shall select three representatives from each of the five departments as nominees for the alumni in good standing in the association to vote upon. Votes may be cast in person or by mail. After the election of the five members of the council they shall determine by lot who are to serve for one, two, three, four or five years, respectively.

Any vacancy is to be filled by the remaining members of the Alumni Council from the department from which the member was originally chosen. The secretary of the General Alumni Association shall act as the secretary of the alumni regents, who shall select their own chairman for one-year terms.

The committee consisted of the following well-known alumni of the five departments of the University:

Medical—Dr. B. Merrill Hopkinson and Dr. E. F. Cordell.

Pharmacy—Dr. John F. Hancock and Dr. J. Emory Bond.

Dental—Dr. L. H. Farinholt and Dr. Joseph C. Heuisler.

Law—Messrs. B. Howard Haman and Jas. W. Bowers, Jr.

Academic (St. John's College)—Dr. J. Frederick Adams and Dr. A. L. Wilkinson.

No further action, however, can be taken in the matter until approved or vetoed by the Board of Regents.

The president, John B. Thomas, Phar. D., introduced the toastmaster, Henry P. Hynson, Phar. D., who was in a particularly bright and witty mood. The speakers were: Hon. J. Barry Mahool, the Mayor of Baltimore; John C. Hemmeter, M. D.; Addison Mullikin, Esq., LL. B.; Charles Caspari, Phar. D.; Joshua W. Hering, M. D., Comptroller of the State of Maryland and a graduate of the class of 1855, of Westminster, Md.

Those who were not present do not know what they missed. It was a live banquet, something doing every minute, and the committee in charge of the arrangements are to be congratulated upon the thoroughness with which they accomplished their task.

Committee—T. O. Heatwole, chairman; Oregon Milton Dennis, LL. B.; Eugene Hodson, Phar. G.; Arthur M. Shipley, M. D.

Among those present were: William Tarun, Dr. J. W. Bird, J. Huff, Dr. Compton Reilly, J. Cromwell, Dr. Randolph Winslow, Dr. R. B. Hayes, C. V. Mace, L. M. Allen, Dr. R. H. P. Bay, Dr. I. J. Spear, H. H. Richards, Dr. J. F. Hawkins, Dr. W. V. S. Levy, T. Marshall West, S. W. Moore, I. H. Davis, Dr. C. V. Matthews, F. J. Valentine, E. B. Howell, A. P. Scarborough, G. F. Dean, G. A. Bunting, John C. Uhler, C. S. Grindall, Dr. J. C. Hemmeter, Dr. A. M. Shipley, John Henry Keene, Dr. Robert L. Mitchell, Judge H. Stockbridge, N. H. D. Cox, Dr. J. H. Holland, Dr. Charles Caspari, Jr., H. P. Hynson, F. V. Rhodes, J. E. Hengst, O. C. Harris, A. S. Binswanger, Dr. St. Clair Spruill, Dr. E. F. Cordell, Dr. Nathan Winslow, Dr. J. M. Hundley, Daniel Base, Dr. Charles E. Sadtler, Addison Mullikin, H. W. Jones, Dr. G. Lane Taneyhill, Dr. L. B. Henkel, Jr., Dr. I. C. Dickson, F. J. S. Gorgas, Dr. T. O. Heatwole, J. W. Bowers, Jr., Dr. J. W. Hering, Alfred E. Kemp, Oscar B. Thomas, J. B. Thomas, Eugene W. Hodson, John F. Hancock, W. M. Fouch, D. R. Millard, Emory Bond, C. A. Volkmar, Frank Black, H. P. Hynson, J. W. Westcott, Dr. C. H. Medders, B. Elliott, Dr. Eugene Cordell, Leroy Oldham, A. R. Dohme, B. A. Lillich, Oregon Milton Dennis, L. W. Farinholt, T. E. Latimer, Ambrose Murphy, Dr. Henry Kennard, Dr. Herbert Zepp.

The "Clinic," the year book of the College of Physicians and Surgeons, Baltimore, which has just been issued, is dedicated to the memory of the late Dr. Isaac Ridgeway Trimble, who gave his life that another's might be saved. Dr. Trimble was a graduate of the University of Maryland, class of 1884, and at the time of his death was Professor of Anatomy in the College of Physicians and Surgeons.

Dr. A. J. Edwards, class of 1898, of Bristol, Tenn., is spending a few days around the Hospital renewing old acquaintances.

Dr. Luther Bare, of Westminster, Md., was a recent visitor to the University Hospital.

The banquet of the Medical Alumni Association will be held on the evening of May 31, 1909.

Dr. and Mrs. B. Merrill Hopkinson, who have been spending the week at the Hotel Chamberlin, Old Point Comfort, Va., have returned to the city.

The University of Maryland baseball team defeated the Midshipmen on the Naval Academy grounds recently by the score of 2 to 0. Anderson, the box artist, struck out twenty of the middies. The team this year has been more than successful, and compares favorably with the teams of the larger colleges. It is undoubtedly the premier team of Baltimore this year, and in any other institution would arouse untold enthusiasm by its notable victories.

Dr. Fitz Randolph Winslow, class of 1906, of Hinton, Va., paid a flying visit to the Hospital recently.

Dr. J. W. Hering, class of 1855, of Westminster and State Comptroller, who has been visiting his son and daughter-in-law, Dr. and Mrs. Joseph T. Hering, at the St. Paul, Baltimore, has returned to his home, in Westminster.

Amongst those who responded to toasts at the recent banquet of the local branch of the Haverford College Alumni Association was Dr. Henry M. Thomas.

Dr. Fitz Randolph Winslow writes from Hinton, Va., in the Valley of the Shenandoah, the garden spot of Virginia, and for picturesque scenery unexcelled in no part of the world, that he is doing nicely. He has seen three goitres and heard of a wonderful cure for the same from an old mountain woman. She took her own medicine, and claims to have been benefited, so he gives the recipe: Put your hands behind your back, bend over and take a horse's head between your teeth. Unfortunately, he forgot to find out the statuo quo of the horse, so you might try the dead or the quick, as suits your convenience. Her goitre is still very apparent, but, sad to relate, she has no teeth left with which to finish the job. This is only one specimen of the gross ignorance and superstition of the hill people. They treat or mistreat themselves often when ill principally by making teas of various herbs, such as boneset, etc. Skunk oil is a panacea both internally and externally. He expects no respectable disease can live in the same neighborhood with such an odoriferous medicament.

Dr. John Chaplain Travers, class of 1895, of Cambridge, who recently left for the Philippines, where he will enter the government service, gave a farewell entertainment before leaving at the residence of Capt. James C. Leonard.

Dr. J. Clement Clark, superintendent of the Springfield State Hospital, presided at the third meeting of the Maryland Psychiatric Society, which was held at the Sykesville institution. Among those present were: Drs. J. C. Clarke, Marshall L. Price, Wm. F. Wohwartz, R. R. Norris, F. J. Flannery.

It gives us pleasure to announce that Dr. Charles H. Mayo, of Rochester, Minn., one of the renowned Mayo brothers, has accepted the invitation of the Faculty of Physic to deliver a course of lectures on diseases on the thyroid gland in the fall.

Dr. Lee Cohen, of Baltimore, will read a paper at the coming meeting of the American Medical Association on "Post Operative Tonsillar Bleeding: Its Surgical Control, with Mention of Cases;" Dr. R. L. Randolph, of Baltimore, on "Rodent Ulcer of the Cornea;" Dr. Samuel Theobald, of Baltimore, on "Reflex Aural Neurosis Caused by Eye Strain, with Report of Cases."

One of the marked developments of the Democratic State Central Committee was a practically unanimous sentiment in favor of the renomination of Dr. Joshua W. Hering, class of 1855, for State Comptroller. State and county leaders were outspoken in their opinion that Dr. Hering's popularity throughout the state, as well as his excellent record as Comptroller, make his nomination virtually a matter of course.

The condition of Dr. R. A. Warren, of Hot Springs, Va., class of 1907, who was operated on recently at the University Hospital for appendicitis, is reported to be favorable.

Dr. Randolph Winslow desires to acknowl edge cards from Drs. M. Zaki and M. Teufik, 166 Mohamed Aly street, Cairo, Egypt. These are two of our popular Egyptian students, and are located as noted above, where they have met with unexpected success. Drs. Heilig, Moose, Kerr and Pearlstine, four of our recent Southern alumni, paid their respects to the University recently. The three former are located in North Carolina, the latter in South Carolina.

The last regular meeting of the University of Maryland Medical Association was held in the amphitheatre of the University Hospital, Wednesday, April 21, 1909, and the program was as follows: 1. "Preliminary Training Necessary for Those Contemplating the Study of Medicine," Dr. Randolph Winslow; 2, "The Teaching of Therapeutics," Dr. C. W. Mitchell; "The Teaching of the Specialties," Dr. Hiram Woods.

The meeting was well attended and the papers were both instructive and interesting. Dr. A. M. Shipley, the president, occupied the chair. This is the last meeting of the society until the fall. Dr. Woods' paper appears elsewhere in this number.

Dr. Richard H. Johnston, of Baltimore, will read a paper on "Benign Tumors of the Turbinate Bodies Clinically and Pathologically Considered," at the coming meeting of the American Medical Association.

The Council on Medical Education of the American Medical Association in its annual report has this to say concerning college mergers:

Another encouraging fact to be noted is the mergers being made among medical schools whereby stronger schools are resulting. Notably in Indiana, all of the regular schools in the state merged into the medical department of Indiana University, while in Kentucky all of the medical schools merged into the University of Louisville. In Cincinnati the two regular schools merged into the University of Cincinnati; in Minnesota Hamline merged into the medical department of the University of Minnesota.

There are numerous other cities where mergers might be brought about if those interested in general education and those in medical education in each city would work together to secure them. For example, if all the medical colleges of any large city, such as Chicago, Philadelphia, St. Louis or others, could be merged into one great university medical school, such as are to be found in Berlin, Paris or Vienna, it would be of the greatest possible advantage to medical education in America.

In the evolution of general and medical education in this country it is becoming more and more evident that a well-rounded university needs a strong medical department, and it is now equally clear that a medical school cannot reach the highest stage of its development except as the medical department of a strong university. It is evident that within a few years the medical schools of this country will, with few exceptions, be the medical departments of universities. Fortunately for the medical school, the university needs the medical school quite as much as the medical school needs the university, so that almost any independent

medical school of real merit can secure desirable union with a university. And this change will solve most of our present problems in medical education.

Since our last conference there have been five important mergers of medical colleges by which nine medical schools are replaced by four stronger ones. These mergers were as follows:

1. At Louisville, Ky., the Louisville and Hospital Medical College, the Kentucky School of Medicine and the University of Louisville Medical Department united, retaining the name of the University of Louisville Medical Department. This leaves but one regular medical college in Louisville, where there were five colleges two years ago. As a direct result of this merger, the school has received $25,000 from the city of Louisville, and steps have been taken to build a new city hospital, which is to be largely under the control of the medical school.

2. At Cincinnati the merger between the Medical College of Ohio and the Miami Medical College has been completed, the new school to be the Medical Department of the University of Cincinnati. The building of an enormous new city hospital has already been started near the university campus, and a new medical college building will be erected adjoining this hospital. The outlook for this new school is very encouraging.

3. The Keokuk Medical College, College of Physicians and Surgeons, located at Keokuk, Iowa, has turned all its property and good will over to the Drake University, College of Medicine, at Des Moines, Iowa.

Amalgamation of the Cooper Medical College with Leland Stanford University is announced. Henceforth the San Francisco institution will be designated the School of Medicine of Stanford University. The affiliation was given approval sometime ago, and it only remained for the board of trustees of the University to formally accept the gift.

Why can't the independent medical colleges of Baltimore come together? Such an event would accrue to the best interests of all concerned, and would greatly tend to eliminate Baltimore as one of the dark spots upon the medical educational horizon.

NURSES WIN DIPLOMAS.

In spotless white and amid a bower of flowers, 16 pretty young women were handed their diplomas yesterday as graduates of the University Hospital School for Nurses by the Dean, Prof. R. Dorsey Coale. There were 17 nurses to graduate this year, but one of them, Miss Catherine M. Dukes, is seriously ill and could not attend.

After the conferring of degrees Dr. Arthur M. Shipley gave the young nurses advice as to their future. The opening prayer was delivered by Rev. Edwin B. Niver, rector of Christ Protestant Episcopal Church, and benediction was pronounced by Rev. Dr. Hemsley, of Oakland, Md.

The hall of the University was crowded with friends and relatives of the graduates. It was decorated with carnations and potted palms, and around the pillars was twined black and red bunting, the University colors. The nurses, preceded by Professor Coale and Dr. Shipley, entered the hall in pairs, carrying bouquets of Marguerites.

Dr. Shipley said that much of the nurses' training had been under his supervision, and he felt a personal interest in them. Women, he said, invariably scared him, but someone informed the physician that was not always so, for Dr. Shipley is to become a benedict today.

"You have chosen a work that is second to none in the world," said Dr. Shipley. "You have before you possibilities that are almost limitless. You are on the threshold of a life that is to be of your own making, for the chief danger of the individual nurse is drifting. It is so easy to forget the old-time standards and call them old-fashioned. Old-fashioned they may be, but they have stood the test of generations of correct living and thinking."

At night the graduates were given a farewell reception and dance by the undergraduates.

Dispensary Report, April, 1908, to April, 1909.

OF

UNIVERSITY HOSPITAL

Department.	New Cases.	Old Cases.
Surgical	1,703	4,448
Medical	1,709	3,199
Genito Urinary	765	2,933
Nervous	399	1,971
Women	733	1,270
Stomach	421	1,108
Throat and Nose	622	1,039
Children	761	997
Eye and Ear	712	903
Skin	473	907
Tuberculosis	190	703
Orthopedic	31	120
	8,519	19,609

Total new cases... 8,519

Total old cases.... 19,609

Grand total..... 28,128

JOHN HOUFF, M. D.,
Dispensary Physician.

DISPENSARY PHYSICIANS AND CHIEFS OF CLINIC.

Medical Department—Dr. J. M. Craighill, Chief of Clinic; Drs. W. H. Smith, G. C. Lockard, J. F. O'Mara, R. C. Metzel, H. J. Maldeis, A. B. Hayes, H. D. McCarty, E. S. Perkins, J. F. Adams, H. L. Sinsky, Clarke, Todd.

Surgical Department—Dr. John G. Jay, Chief of Clinic; Drs. M. T. Cromwell, T. A. Tompkins, Jr., J. F. Adams, J. H. Smith, R. B. Hayes.

Stomach Department—Dr R. A. Warner, Chief of Clinic; Dr. W. W. Eichenberger.

Nervous Department—Dr. J. F. Hawkins, Chief; Drs. G. M. Settle, F. J. Wilkins, N. M. Owensby.

Throat and Nose Department—Dr. H. C. Davis, Chief of Clinic; Dr. L. J. Goldbach.

Eye and Ear Department—Dr. E. E. Gibbons, Chief of Clinic; Dr. Wm. Tarun.

Women Department—Dr. Wm. K. White, Chief of Clinic; Drs. H. W. Brent, E. S. Perkins, R. L. Mitchell.

Genito Urinary Department—Dr. Wm. D. Scott, Jr., Chief.

Skin Department—Dr. J. R. Abercrombie, Chief.

Children's Department—Dr. A. B. Lennan, Chief; Dr. H. Schoenrich.

Tuberculosis Department—Dr. Gordon Wilson, Chief.

Orthopedic Department—Dr. Compton Riely, Chief; Dr. S. Demarco.

JOHN HOUFF, M. D.,
Dispensary Physician.

MARRIAGES.

Dr. Wm. B. Warthen, class of 1905, of Bartow, Ga., an ex-resident gynecologist in the University Hospital, and one of the most popular members of his class, a hale fellow and one of the most loyal alumni of the University of Maryland, was married at Macon, Ga., April 15, 1909, to Mrs. Sallie Bell Newsom, of Davisboro, Ga. The Bulletin and friends of Dr. Warthen extend to him their best wishes for a long, successful and happy marriage.

Mrs. Lavinia E. Thomas has issued cards announcing the marriage of her daughter, Miss Alice Saunders Thomas, to Dr. Edward Barney Smith, class of 1907, on April 21st, 1909, at Creeds, Virginia. Dr. and Mrs. Smith will be at home after May 1, 1909, at Woodleigh, N. C.

The marriage of Miss Helen Ashby, daughter of Prof. Thomas A. Ashby and Mrs. Ashby, to Mr. Harry T. Giddings, of Baltimore, took place April 28, 1909, at the residence of her parents, 1125 Madison avenue, Baltimore.

Miss Edna Wright, only daughter of Mr. K. J. Wright, a prominent merchant of Hurlock, Md., and Dr. G. Roger Myers, a well-known physician of Hurlock, were married Wednesday afternoon, April 28, 1909, at the home of the groom's parents. Rev. L. F. M. Myers, of Philadelphia, a brother of the groom, officiated at the ceremony. After a honeymoon spent at Atlantic City and other Northern points of interest, the couple will make their home at Hurlock.

Miss Julia C. Cherbonnier, of Baltimore, and Dr. Eugene F. Raphel, class of 1906, of Wheeling, were married at St. Ann's Catholic Church March 12, 1909, by Rev. C. F. Thomas, assisted by Rev. Wm. M. Clements. The bride was given in marriage by her father, Capt. A. V. Cherbonnier. Her maid of honor was Miss Jeannette Raphel, sister of the groom. The groom was attended by his brother, Alexis A. Raphel. Among the ushers were Dr. J. Holmes Smith, Jr. Dr. and Mrs. Raphel will make their home at Wheeling, W. Va.

Dr. Arthur Marriott Shipley, class of 1902, for a number of years assistant resident surgeon, and later superintendent of the Univer-

sity Hospital, now associate professor of surgery, University of Maryland, was married May 6, 1908, at Eutaw Place Baptist Church, at 8.30 P. M., to Miss Julia Armistead Joynes, daughter of Mr. Tully Armistead Joynes, of Baltimore.

DEATHS.

Dr. Hugh A. Maughlin, class of 1864, of Baltimore, died Saturday, April 17, 1909, at his home, 121 North Broadway, Baltimore. Dr. Maughlin was a prominent member of the Grand Army of the Republic. Rev. J. Wynne Jones, pastor of Abbott Memorial Church, Highlandtown, who is the chaplain of Wilson Post, of which Dr. Maughlin was a member, conducted the funeral services. Burial was in Greenmount Cemetery.

Dr. Newton Clark Stevens, class of 1875, a member of the Louisiana State Medical Society, died at his home, in Ama, January 28, 1909, aged 62.

Dr. Howard E. Mitchell, class of 1882, of Ellerslie, Md., died at the Western Maryland Hospital, Cumberland, Md., April 6, 1909, 48 hours after having been struck by a train, aged fifty-four.

Recently at Cavite, Philippine Islands, Mrs. Mary Gibbs Morris, wife of Dr. Lewis Morris, class of 1890, surgeon United States Navy, was gathered unto her father. Her husband was born in Baltimore, and is the son of the late Capt. C. Manigault Morris, commander of the Florida, Confederate States Navy.

Dr. William Hungerford Burr, class of 1884, a member of the American Medical Association, for four years surgeon in charge of the Santa Fe System Hospital and surgeon to the Clark Coal Company, Gallup, New Mexico, died in the Santa Fe Hospital, Albuquerque, New Mexico, April 13, 1909, from pneumonia, aged forty-nine.

Dr. Edgar T. Duke, one of the most prominent physicians of Allegany county, died April 3 at his home, on Bedford street, Cumberland, the result of an attack of pneumonia. He was 43 years old, a son of Major and Mrs. J. E. Duke, and was a native of Charlestown, W. Va., coming to Cumberland with his parents when a young man. He studied pharmacy with the late Dr. John F. Zacharias, and later read medicine under the late Dr. G. Ellis Porter at Lonaconing, graduating at the University of Maryland in the class of 1891.

Dr. Duke was in love with his profession, and was for a number of years secretary of the Allegany County Medical Association. He was prominent before the association for his special papers, and was also prominent on the church lecture platform. Hardly a church in Cumberland but that has had Dr. Duke's services.

He was a member of Chosen Friends' Lodge, No. 34, Independent Order of Odd Fellows, of which body he was secretary for some years, and also a past presiding officer, and was connected with other fraternal organizations.

Dr. Duke was also a member of the American Medical Association, the Medical and Chirurgical Faculty of Maryland and the Tristate Medical Association. He assisted in organizing the Western Maryland Hospital Training School for Nurses and was one of the lecturers. He was an elder and the Sunday school superintendent in the Presbyterian Church.

He was noted for his kindness. He was also active in the Young Men's Christian Association and was chairman of the boys' work committee. His father is a prominent Confederate veteran. His funeral took place Thursday afternoon, April 15, from the First Presbyterian Church. At the present time Dr. Duke's aged mother is very ill.

Dr. Duke leaves a widow, formerly Miss Gardner; his parents, one brother, Mr. Harry

K. Duke, and one sister, Mrs. Mary Campbell, all of Cumberland.

Dr. Edward Pontney Irons, an alumnus of the University of Maryland, and one of the oldest physicians in the city, died Sunday, April 4, 1909, at the home of his sister, Mrs. William P. Lowry, 1023 Harlem avenue. He was 84 years old.

He was born in this city, a son of Dr. James and Rebecca Irons, who were of English and French-Irish ancestry, and descendants of the earlier settlers of the state. He entered business and was variously employed in a number of the Southern States. In 1863 he returned to this city and entered the University of Maryland.

After graduation in 1865, when the Civil War was nearing its end, he acted as assistant surgeon in the Officers' Hospital at Annapolis. A year later he went to Alabama, but remained only a short time. He returned and opened a practice here, which he maintained.

He retired from active work about seven years ago. At that time he was subordinate medical examiner for the Royal Arcanum, of which he was a member. He was also a member of the Masons, the Baltimore Medical Society and the Medical and Chirurgical Faculty of Maryland.

In 1857 he married Miss Anna Rebecca Sewell, a daughter of Thomas H. Sewell, a Baltimore manufacturer. A daughter, Mrs. James W. Ramsey, is the only survivor.

Dr. Benjamin Franklin Laughlin, class of 1904, died at his home, at Deer Park, Md., aged 31 years. He first located at Blaine, W. Va., where he practiced. He was taken ill at Kingwood, W. Va., some months ago, and was later sent to a Baltimore hospital, but he showed no signs of improvement. He was a son of Dr. and Mrs. J. W. Laughlin, Deer Park, and a brother of Hice Laughlin, a prominent Baltimore and Ohio official, Grafton, W. Va.

Dr. George C. Farnandas, class of 1852, of Baltimore, died Sunday, April 4, 1909, at his home, 1721 Maryland avenue, Baltimore, of old age. The funeral took place from his late home, 1721 Maryland avenue. Dr. Farnandas was 80 years old. Before the Civil War he had a large practice, but gave it up so that he might travel. He was well known to the older generation of Baltimoreans. The services were conducted by Rev. J. H. Eccleston, rector of Emmanuel Church.

The honorary pallbearers were Dr. N. K. Keirle, Dr. James M. Craighill, Dr. Samuel T. Earle, Mr. Thomas H. Robinson and Mr. Wm. P. Trimble, of Harford county. Burial was in Greenmount Cemetery.

Mrs. Virginia Blackwell Carder, aged 38 years, wife of Dr. George M. Carder, class of 1891, of Cumberland, Md., died March 17, 1909, after a struggle of two weeks against the ravages of a mastoid abscess.

Mrs. Carder was preparing to visit her sister, Mrs. Gay Breton Leroux, in Douglas, Ga.

Suddenly she was stricken, and when an operation became necessary Mrs. Carder insisted that her husband, a surgeon who has kept constant vigil the last two weeks, perform the operation. The operation was apparently very successful, and Mrs. Carder was improving, when complications in the form of typhoid fever set in. Prof. C. W. Mitchell, of Baltimore, and Drs. J .T. Walker and Harry Hyland Kerr, of Washington, were called by Dr. Carder, and all said everything possible was being done for her, but held out no hope.

Mrs. Carder was the daughter of Thomas Callan, of Narrows Park, and, besides her husband, leaves a little son (Robert Callan Carder), two brothers (George S. Callan, of Duffields, W. Va., and Charles T. Callan, of Little Orleans, Md.), and one sister (Mrs. Leroux). Miss Mary L. Callan, a sister, was accidentally drowned in the Potomac at Little Orleans.

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A CLINICAL STUDY OF ECTOPIC PREGNANCY, WITH A REPORT OF FORTY-FIVE CASES.

BY THOMAS A. ASHBY, M D.,

Professor of Diseases of Women in the University of Maryland, Baltimore, Md.; Fellow of the American Gynecological Society, etc.

I wish to relate my personal experience with ectopic pregnancy in order to show from a study of 45 patients operated on some points of interest in the clinical history, diagnosis and treatment of this condition. The number of cases coming under the observation of a single operator is sufficient evidence of the frequency of the condition. I wish to show from a study of my own cases that the clinical history of ectopic pregnancy presents a strong argument in favor of the importance of prompt diagnosis and radical treatment of a dangerous pathologic condition. Whatever view we may take of the etiology of ectopic pregnancy, one important fact is shown in the danger which attends the condition. Whilst a failure to interpret symptoms and delay in diagnosis and treatment often lead to unfortunate results, it will be shown in this series of cases that the diagnosis is not usually made until the patient has reached the operating table, and that the surgeon at times is dealing with results of long standing, and in other cases of immediate importance.

My first patient was operated on in June, 1889, my last in May, 1909. Of the 45 patients, 44 recovered and one died.

CASE I.—Mrs. D., age 25 years, married five years, and mother of one child, age four years, was referred to me by her family physician, the late Dr. George R. Graham, of Baltimore. Menstruation was suppressed two months. No other symptoms of pregnancy were present. About the tenth week after her menstruation had ceased she was seized with violent pain in the left ovarian region. Dr. Graham was called in, and upon examination detected a small movable tumor to the left of the uterus and very low in the pelvis. He suspected a tubal pregnancy and put the patient to bed. Four weeks later the patient was again seized with violent pain in the same region, followed by a slight collapse and shock. Upon examination Dr. Graham found that the tumor had disappeared. On the following morning menstruation reappeared, but the pain continued. Ruptured tubal pregnancy was strongly suspected. I saw the patient in consultation the following day. An examination was made under anesthesia, but no satisfactory condition could be made out beyond some slight indication of a small movable tumor to the left of the uterus high up in the pelvis. After a few days the patient was able to resume her domestic duties. She was free from pain from April 10, the date of consultation, until the first week in June, when violent pains returned in the same region. This continued until June 10, when I again saw her in consultation. At this time a small but movable mass was felt in the left pelvic region. As the patient was in great distress, an operation was proposed and accepted. On June 11 a celiotomy was done at the patient's home and the tumor was removed. It proved to be the left ovary containing a small blood clot partially ruptured into the folds of the left broad ligament. The patient made a prompt recovery.

The pathologic report proved to be most interesting. The specimen was examined for me by Dr. W. H. Welch, of the Johns Hopkins Medical School, who found that it was composed of the lateral extremity of the Fallopian tube, the ovary, a sac containing blood coagula and fetal membranes, and a unilocular cyst with the corresponding part of the ligamentum latum. Dr. Welch's report says: "There is no doubt that the case is one of ovarian fetation. It is not possible to exclude positively the participation of the wall of the tube in the formation of the sac containing fetal remnants, so that the case may be possibly a tubo-ovarian pregnancy."

The occurrence of ovarian pregnancy has been denied by the majority of observers on the ground of the physical impossibility of the im-

pregnated ovum being surrounded by ovarian tissue. The few cases reported can hardly be considered as positively proven, and probably should be regarded as belonging to the tubo-ovarian variety, as shown in the case here reported. This variety must of necessity be very rare. An early termination of gestation is invited by the physical conditions which surround the impregnated ovum. Danger from rupture of the sac and hemorrhage should be less than in any other variety.

Case II.—This patient was seen in consultation with Dr. Arthur Williams, of Elk Ridge, Md. Mrs. M., aged 30 years, was seized with violent pains in the pelvis, followed by symptoms of collapse. She had the usual signs of pregnancy advanced to the eighth or ninth week. Dr. Williams was called in, and after examination diagnosed the case as one of ruptured tubal pregnancy. I was invited to see the patient in consultation, and confirmed the diagnosis. The patient was advised to go to the Maryland General Hospital for immediate operation. Owing to her condition and to unavoidable delay in moving her from her home in the country, the operation could not be done for some five days after the rupture. In the meantime symptoms of infection had supervened and the general condition of the patient was much depressed. When the section was made a large hematocele filled the pelvis; the left tube had ruptured and contained placental debris. The blood and placenta were macerated and semi-decomposed; peritonitis, both local and general, had started up. The pelvis was emptied of blood clots and cleaned as thoroughly as possible by removing the damaged tube and other infected tissue. The operation presented a number of difficulties, owing to the extent of the hematocele and inflammation of the peritoneum, which had given rise to adhesions and inflation of the intestines.

The patient came out of the operation with great shock from the previous loss of blood and from the extent of the procedure instituted for her relief. Her pulse at the time of the operation was 135 and temperature 102°F. Rally from shock was slow. General peritonitis was well established on the fourth day, the abdomen was greatly distended, nausea was extreme, and bowels were confined. The patient was so ill that her life was despaired of. I decided that the only measure that could save her was free purgation. I gave her one grain (0.06 gram.) of calomel every hour for thirteen hours. At the end of that time her bowels began to move and she purged copiously until it became necessary to use restoratives. The free purgation soon relieved all of her symptoms, and she began at once to make rapid progress toward recovery.

This experience confirmed my faith in the value of calomel after abdominal operations, and from that time to the present I have found it the most reliable of all drugs in post-operative cases when free purgation is required. It has one great advantage in the fact that it is not given in bulk and is not easily rejected by the stomach. It is seldom necessary to give more than one to three grains, in quarter, half or one-grain doses, at intervals of one hour, to bring on a free bowel movement. In this connection I may mention the value of salicylate of eserine in one-fortieth of a grain (0.0015 gram) doses given hypodermically in cases of apparent bowel obstruction following abdominal operations. Several recent experiences have showed the marked efficacy of this new remedy, and have demonstrated the rapidity of its action. During May, 1905, after an operation for the removal of an ovarian cyst, the patient's bowels refused to move, and symptoms of obstruction were so marked that a reopening of the abdomen was seriously considered. All other agents had failed, whereupon I gave the patient a hypodermic injection of one-fortieth of a grain of eserine salicylate. In less than thirty minutes a free bowel movement was brought on and all symptoms of obstruction disappeared. No unpleasant effects followed the use of the drug, and subsequent experiences have shown its great value in similar conditions.

There is no more important condition in the after-treatment of abdominal operations than intestinal torpidity. This condition should be watched from the very beginning, and should be relieved at once if a speedy convalescence is desired. I make it a rule to empty the intestines freely before every operation requiring anesthesia. This may obviate the necessity for an early bowel movement after the operation, but it does not do away with a careful oversight of the intestinal condition which may call for the early and free use of purgation. Observation will show that in the vast majority of operative cases, when the bowels and kidneys are acting well a speedy convalescence may be expected.

Case III.—Presents no important clinical symptoms.

Case IV.—Was a widow of some two years

standing, 30 years of age, and had not borne a child. Pregnancy was not suspected. When I was called to see her I found her critically ill with sepsis. Her pelvis was filled with a large mass which I assumed was a pus accumulation. An immediate operation was advised, but over twenty-four hours' delay occurred in getting the consent of her friends and in removing her to the hospital where the operation could be done. The patient's condition grew alarming in this interim. When the section was made a large encysted hematocele, with ruptured tube containing placental debris, at once explained the etiology of the inflammatory condition and the origin of the systemic infection. General peritonitis and sepsis were well under way when the abdomen was opened. The intrapelvic condition was removed as thoroughly as possible, but it was too late to arrest the blood infection, which destroyed her life on the fourth day after the operation. The social position of this patient misled her physician in arriving at a prompt diagnosis in the early stage of the attack. The rupture of the tube and the hematocele most probably took place a few days before he was called in. He had no way of knowing the etiology of her condition, and was forced to treat it as an ordinary intrapelvic inflammation. The patient found it necessary to conceal her true condition from her friends and from her physician, and it was not discovered until she was on the operating table. Her friends have no knowledge of the primary cause of her death.

Cases V. and VI.—Presented the ordinary physical signs of intrapelvic hematocele, and when the abdomen was opened the origin of the hematocele was found in a ruptured tube with the usual changes indicating the beginning of tubal gestation. Rupture occurred in the early weeks of gestation, and the remnants of fetal life had disappeared with the exception of the placental debris. Both patients made uneventful recoveries.

Case VII.—Presented the history of pregnancy advanced to the twelfth week. Symptoms of primary rupture were not present, but the physical signs pointed to tubal gestation. A positive diagnosis was made and the abdomen opened in anticipation of a possible rupture at any moment. The left tube was removed, being enlarged and distended with the placenta and embryo advanced to the third month of development. The tube wall was so thin from distension that in the manipulations connected with its removal it ruptured and expelled a living fetus. Primary rupture would undoubtedly have occurred within a few days had not the section been made. A prompt diagnosis and removal of the tube prior to rupture made the operation a very simple procedure, and the recovery of the patient brought a prompt conclusion to her invalidism.

Case VIII.—Presents no unusual clinical symptoms. This case was the only one in this series of 45 cases treated by the vaginal route.

Case IX.—The diagnosis of pregnancy was not positive. The physical signs were those of a large intrapelvic tumor most probably of fetal origin. Upon abdominal section a ruptured tube was found with a ten weeks' fetus, covered up in the debris. The case presented no history of rupture, such as pain, collapse or shock. The leakage from the ruptured tube was small and indications of absorption of the blood clot were quite manifest. It is probable that a long delay in operating would have led to an almost total removal of the blood, and to an encysted condition of the fetus, as no evidences of infection were present. With the removal of the tube and debris the patient made a prompt recovery.

This case illustrates the probable behavior of a class of cases in which nature is successful in removing the debris of a tubal rupture and in disposing of the fetus through either gradual absorption or by enclosing it in a distinct sac, where it may remain buried in the tissues for years. In Case XVIII. of this series there is a history of this condition in which the fetal bones finally worked through the wall of the abdomen and led to an infection of the sinus leading down to the bed in which the fetal remnants were encysted. It is interesting to observe how nature attempts to deal with these foreign bodies, and with what success when infection is not present. The early rupture of the tube may no doubt take place in many cases with complete recovery and final disappearance of the products of conception, and in this manner explain how it is that pelvic hematoceles often go on to complete absorption and disappearance.

Case X.—This patient presents no important points for study.

Case XI.—Upon examination a tumor the size of a baseball was found in the left ovarian region. She presented a history of pregnancy of some eight weeks' duration. The diagnosis of tubal pregnancy was made and she was advised to go to the hospital for immediate operation, as symp-

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

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

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

Case XII.—This patient presented the usual symptoms of pregnancy—suppression of menstruation, enlargement of the breasts, morning sickness, and slight increase in the size of the uterus. Upon examining her pelvis a large tumor, presenting the signs of an enlarged tube, was found in the left pelvic region. The diagnosis of left tubal gestation was made. No indications of a threatened tubal rupture were present, but it was decided to operate at once and forestall such an occurrence. Upon opening the abdomen in the median line the tumor was easily reached and drawn out through the incision. In the manipulation attending the withdrawal of the tube it ruptured and a small living fetus was expelled. The tube was tied off close to the uterus and removed. The operation required only a few minutes and was attended with but little loss of blood. The recovery of the patient was uneventful.

Cases XIII. and XIV.—Present no unusual clinical features.

Case XV.—Mrs. M., the mother of four children, presented all the rational signs of pregnancy. Nausea and vomiting were incessant and continued for several weeks, until emaciation and depression were extreme. An examination of the pelvis was then made to determine the condition of the uterus, but nothing satisfactory was revealed. At this time the gestation was believed to be normal. During the third week the nausea suddenly ceased and the patient began to take nourishment. The patient then had a rise of temperature, followed by symptoms of intrapelvic inflammation. There were no symptoms of tubal rupture, but the sudden arrest of nausea, and development of intrapelvic inflammation, led to the opinion that the gestation had been arrested and its tubal origin was strongly suspected. This led to a careful examination under anesthesia, when a small mass in the left ovarian region was discovered. The uterus was only slightly increased in size. Tubal pregnancy was so strongly suspected that it was decided to open the abdomen on the following day. When the section was made the left tube was found en-

larged to the size of a hen's egg. In the canal of the tube was a small gestation sac unruptured, but containing only placental tissue. Fetal death had occurred so early that its absorption was complete. A mild infection had begun in the tube, and this no doubt had caused the rise of temperature. With the removal of the tube the patient was soon restored to health.

In this patient there was an unusual disturbance of her digestive organs following conception, but this subsided with the death of the embryo. But for an infection of the tube containing the fetal remains a complete subsidence of the trouble would probably have taken place. It is interesting to inquire whether an infection of the tube brought about an arrest of the gestation or followed in the wake of the embryo's death? Could this question be answered in the affirmative it might explain how the death of the embryo is brought about in the first few weeks of gestation in certain cases.

Case XVI.—Mrs. B., a multipara, age 35 years, was admitted to the University Hospital from North Carolina. At the time of her admission she was critically ill with an acute intrapelvic inflammation, the origin of which could not be explained by her history. A large mass filled the pelvis and presented all the physical signs of an acute salpingitis. An abdominal section was made as soon as the patient could be prepared for the operation. The mass was found to be a large encysted hematocele, due to a ruptured tube, induced by the overdistension of placental tissue and blood clots. Infection had taken place and the pelvic cavity and contents were actively inflamed. The entire mass was removed and the abdomen closed. The subsequent condition of the patient was satisfactory until the tenth day, when her temperature began to go up and down in an erratic way. An examination of the pelvis and of the abdominal wound showed complete repair and not the slightest signs of infection. Finding in her surgical condition no explanation for the temperature changes, I suspected a typhoid infection, and blood examinations revealed a typical Widal reaction. For the following fifteen weeks the patient ran the course of typhoid fever, and, though much reduced physically, eventually recovered. I am unable to explain the occurrence of the typhoid infection in connection with a tubal gestation except upon the theory that the tubal condition was of long standing and the typhoid infection had rekindled a tubal inflammation, which at once called attention to the intrapelvic condition for which the section was done. The removal of the tubal condition had little influence over the typhoid infection, which ran a typical course. But for the removal of the diseased tube I believe the patient would have lost her life.

Case XVII.—This patient, a colored woman, about 35 years of age, was admitted to the University Hospital to be treated for a large intra-abdominal tumor which was solid in character and freely movable. It was attached to the uterus by a long pedicle, and in its physical aspects seemed to be a solid tumor of the ovary, or a subperitoneal fibroid with an elongated pedicle. There was no history of pregnancy and this condition was not considered. When the abdomen was opened the true character of the tumor was made out. It was found to be a greatly enlarged left tube with the fetus partly expelled from the fimbriated end. The tube was attached to the uterus by a pedicle over six inches in length, the whole mass being so freely movable that it was easily withdrawn through the abdominal incision and detached from the uterus. The operation for its removal took only a few minutes.

This pathological finding is the most interesting of this series of cases, since it explains the manner in which tubal abortions take place and how the tubal variety is converted into the abdominal variety. The body of a dead fetus was enclosed in the cavity of a large tube, whilst the head of the fetus, covered with the amnion, has been expelled, the neck being tightly grasped by the open end of the tube. Before the fetus perished the tube had attempted to expel it into the abdominal cavity, and had its expulsion been complete, and the fetus still viable, the development continuing, the abdominal variety of pregnancy would have resulted. As it happened, the fetus probably perished before its complete expulsion was accomplished, and the expulsive power of the tube was so weakened by the arrest of fetal growth that it remained in the condition in which it was found at the time the abdomen was opened. Just how long the patient had carried this dead fetus I was unable to determine, but from her somewhat indefinite statement as to the presence of the tumor I am led to believe that more than

six months had intervened from the time she first observed it to the time of the operation. Fortunately, the fetus was so hermetically sealed up in the abdomen that infection did not take place, and there was no evidence of absorption. It was dead, but well preserved. There had been some slight escape of blood into the abdomen—shown by the discoloration of the tissues and a few flakes of lymph scattered here and there. The freedom with which the tumor could be moved was probably due to the weight of the mass on the uterine end of the tube, which had elongated by traction.

The origin of the abdominal variety of ectopic pregnancy has been so fully establishd that but few cases can be referred to any other seat of development than the cavity of the tube. This case so beautifully shows how the tubal variety is converted into the abdominal variety that a positive demonstration may be claimed.

Case XVIII.—This patient was a multipara, aged 30 years, admitted to the University Hospital with a small abscess sinus located in the median line midway between the umbilicus and the symphysis. There was no history of pregnancy and the condition was not suspected. Upon physical examination a small inflammatory tumor was found in the left pelvic cavity. There was some fixation of the uterus. Introducing a blunt probe into the sinus, it was easily pushed down into the pelvis until it had reached the tumor mass. This sinus was found acting as a drain canal to the pelvic abscess, and had served as a route for the escape of small fetal bones which were buried in the deeper tissues. An abdominal section was made and the debris of a small fetus, chiefly bones, was found buried in the wall of the abdomen and underlying structures and connected with a ruptured tube coming off from the left horn of the uterus.

The explanation of the condition was now made plain. This patient without her knowledge of pregnancy had carried a fetus in the left tube between eight and ten weeks. The overdistended tube had cast out the fetus and it had been walled off from the general abdominal cavity by a distinct sac wall, the sac subsequently forming close attachments to the wall of the abdomen, through which pus and fetal bones finally made an exit. Here was an intelligent effort upon the part of nature to throw off a dead fetus by the abdominal route. This is the only instance in this series of cases in which an effort was made to eliminate the dead fetus in this manner, and I must assume that there were physical conditions present which made this method possible. After the removal of the debris and damaged tube the patient was restored to good health.

Cases XIX., XX., XXI and XXII.—These cases were operated on in the University Hospital during the years 1903 and 1904. As they were only diagnosed as ectopic pregnancy on the operating table, I shall refer to them very briefly. In each case the patient gave no history of pregnancy, and there were no symptoms which could explain the etiology of their conditions at the time of the operation. In each the physical signs indicated chronic tubo-ovarian disease. After an abdominal section was made and the tube was exposed to view the etiology of the tubal condition was explained. In each instance a ruptured tube was found and placental remnants were present. Evidences of extensive hemorrhage were not found, but indications of attempted repair and of chronic tissue changes were observed. These cases following each other so closely present a history frequently overlooked in intra-abdominal work—a history of minor tubal disease caused by an early arrest of a tubal gestation with an incomplete repair of the damaged organ, followed by symptoms of tubo-ovarian inflammation.

In dealing with this class of patients it is often fair to assume on circumstantial evidence much that cannot be definitely proved. These women had all been exposed to the contagion of gonorrhea, and no doubt had had gonorrheal salpingitis of mild degrees. The arrest of an infection may limit, but not totally destroy, the function of the tube, and thereby favor tubal conceptions and abortions. On such an assumption as this we can explain the frequency of tubal conceptions and early ruptures when no other explanation seems satisfactory. If such an explanation as this is not valid, how are we to explain the frequent occurrence of early tubal ruptures and hematoceles in this class of cases? It is not possible by statistics to prove the extent of the etiologic influence of gonorrhea in ectopic pregnancy, but clinical observation will show how justly we may suspect the preliminary work of the gonoccoccus in this sphere of action.

Case XXIII.—This patient was a young mar-

ried woman admitted to the University Hospital with procidentia uteri. She gave no history of pregnancy. Upon examination the cervix was found external to the vulva, and both external os and fourchette gave no evidence of a previous pregnancy. To the left of the uterus a tumor the size of a base ball could be made out. It presented the physical signs of a small ovarian cyst. When the uterus was pushed up in the pelvis the tumor was movable with it. The diagnosis of ectopic pregnancy was not made until the abdomen was opened and the tumor removed. Upon examination the specimen was found to be a distended tube containing placental debris and coagulated blood. Tubal rupture had not taken place, as gestation had been arrested at a very early stage of development and the contents of the tube had not exercised sufficient pressure to break through its distended walls.

This was clearly a case of arrested gestation without expulsion of the embryo, and well explains how the death of the embryo may occur without serious danger to the patient. A fall, blow or misstep would have been sufficient in this case to cause a rupture of the tube without subjecting the patient to any graver condition than a small hematocele. May not many of the pelvic hematoceles be accounted for in this way? It is only by a study of the pathology of the tube found after operation that we are able to arrive at a correct understanding of the conditions presented. The early death of the fetus in ectopic pregnancy is the most fortunate disposition which nature can make to correct a false step in gestation.

In the case under consideration, the patient had not skipped her menstruation and had neither morning sickness nor enlargement of the breasts. But for the pathologic finding pregnancy would not have been discovered.

Case XXIV.—Mrs. A., age 39 years, the mother of one child, nine years of age, was admitted to the University Hospital in April, 1905, with a history of ectopic pregnancy. Upon examination the entire pelvis was found filled with a doughy mass, which was recognized as an extensive hematocele from a tubal rupture of some days' standing. The blood as it leaked from the ruptured tube had dissected its way through channels made in the loose connective tissues of the pelvis, and had formed a dense coagulum, which enveloped the uterus, tubes and ovaries with one large mass of blood and fibrin. In removing the mass I found it necessary to remove both tubes and ovaries, and to do a supravaginal hysterectomy. After cleaning out the pelvis and abdomen I found so many small lymph deposits and uncovered spaces on the bladder, rectum and small intestines that I was apprehensive that a post-operative infection would give trouble. A puncture was made in Douglas' cul-de-sac into the vagina and a gauze drain was established through this route to provide for the escape of material the peritoneum might not be able to take care of. The abdomen was closed. During convalescence drainage was very considerable, and no doubt contributed to the early convalescence of the patient.

The question of vaginal drainage in this class of cases is very important, and whilst it may not always mean the difference between life and death, it may materially influence convalescence and post-operative symptoms. When there is an assurance that the peritoneum can deal with leakage and debris unavoidably left after an extensive intrapelvic operation, drainage by either route is unnecessary, but when this assurance is involved in grave doubt it will depend upon the judgment of the operator whether he shall drain primarily or wait for positive indications during the post-operative period. Men of experience will always differ in answering this question. The only answer one can give is based upon one's instincts. There is a monitor which seems to suggest a proper line of action in the majority of instances and the man who exercises judgment is less likely to fail than one who is biased in favor of or against a given procedure. The indications for abdominal drainage should be so pronounced that it is accepted or rejected at once. Vaginal drainage, on the contrary, imposes no severe discomfort upon the patient, and the opening may be closed in a few days without difficulty. It provides for a concealed leakage and keeps the operator in closer touch with intrapelvic conditions.

The drain-canal should be accommodated to the condition calling for its use.

In large areas of leaky surfaces considerable packing should be done. In other cases a lamp-wick-drain may be sufficiently large to control the conditions left within the pelvis and to provide an outflow that would occasion trouble if

left to seek its own outlet. Convalescence may be hastened by a properly used vaginal drain or retarded by trusting too much to nature's methods of removing exudates.

Case XXVII.—Mrs. M., multipara, youngest child 15 years of age, had married her second husband four years ago. She had missed two menstrual periods. She had all the usual signs of pregnancy. For several days she had suffered with colicky pains in her pelvis, but attached no importance to them. At 3 P. M. of November 7, 1905, she was seized with violent pains, followed by shock and collapse. Dr. La Bara, her physician, was hastily called in, and upon examination diagnosed a ruptured tubal pregnancy with concealed hemorrhage. He had the patient conveyed to the University Hospital as soon as the ambulance could be obtained. She reached the hospital between 5 and 6 o'clock in a profoundly collapsed condition, with a pulse weak, thready and over 150 per minute, respiration quick and shallow and hemoglobin under 50 per cent. It was necessary to give normal salt injections and strychnin to keep up the flagging circulation. I reached the hospital at 7 o'clock and an abdominal section was imperative at once. The blanched and collapsed condition of the patient gave little encouragement. Upon opening the abdomen over one quart of fresh arterial blood was found in the pelvis and among the intestines. The tubes were hurriedly sought for and the left tube was found ruptured from overdistension on its upper border and still leaking at the site of rupture. It was tied off promptly and hemorrhage at once ceased. The intra-abdominal cavity was thoroughly cleansed and then filled with normal salt solution. No fetus was found. The patient rallied slowly from the operation, and within four weeks' time had regained her loss of blood. But for the prompt abdominal section this patient would have perished in a few hours.

Of the following series of cases, Nos. XXVII., XLIII., XLIV. and XLV. are the only ones that present unusual clinical features. In the cases reported I have given brief descriptions of unusual symptoms and conditions which serve to illustrate the treacherous behavior of tubal gestation.

It will be observed that the question of diagnosis is the all-important question in dealing with the condition. It will also be noticed how seldom the diagnosis is made before the patient reaches the operating table. I have found that over 70 per cent. of the cases operated upon were simple pathological finds. The history of the case and symptoms presented no positive evidence of the condition while the physical examination only revealed intrapelvic masses of tubal or ovarian origin, showing some pathological condition of these organs necessitating an intra-abdominal operation.

Case XLIII. — This patient's history is worthy of record, since it illustrates the extreme degree of involvement of the intra-pelvic space with the debris of an extopic rupture. The patient, 35 years of age, was admitted to the hospital from Virginia. She was greatly reduced in flesh and was critically ill. Physical signs showed a large mass in the pelvis extending well above pubic region. Diagnosis of ruptured pregnancy suspected. History of arrested gestation of some weeks' standing was the only cue to her condition.

She was so weak and emaciated when put on the operating table that strychnia and normal salt infusions were given before she was anaesthetized.

The operation proved to be a very extensive one. It became necessary to remove not only large masses of clotted blood, with both tubes and ovaries, but also to remove the uterus. The disorganization of the pelvic connective tissue and ragged condition of the surrounding structures made it necessary to drain by both vaginal and abdominal routes. The patient was so profoundly shocked by the operation that her death on the table was fully expected. When placed in bed restoratives were used constantly until, after some 36 hours, she began to revive. As drainage was free, her convalescence was slow and tedious, but her recovery was complete.

Case XLIV.—This case presents several unusual symptoms. Mrs. A., age 39, mother of one child, 16 years of age, during a recent visit to Europe began to experience unusual pelvic discomfort. There were no positive signs of pregnancy, but a slight interruption of menstruation for several weeks, followed by a continuous discharge of blood from the uterus, lead to a suspicion of a possible early abortion. During her trip across the ocean and for several weeks after her return home uterine hemorrhage continued more or less freely. Upon examination

a distinct intrapelvic tumor to the left of the uterus. and closely attached to it, was easily made out. The hardness of the tumor and its close attachment to the uterus gave the impression that it was a fibroid. An operation was advised, and some two weeks later was performed. The tumor proved to be an enlarged tube containing placental debris. The foetus had perished early and had been absorbed. The uterine hemorrhage was found to be due to the overflow of blood from the tube, which was leaking through the intra-uterine orifice. This leakage of blood had occasioned the menorrhagia, and had also prevented a rupture of the tube from overdistension. It fortunately prevented an intrapelvic hematocele, so often met with in these cases. At the time of the operation a slight leakage of blood had found its way into the pelvic cavity. This patient made an early recovery.

Case XLV.—This, the last case of this series, was operated on on May 7 last. In some respects it is one of the most instructive of this series. The patient was married, 19 years ago, and had borne no children. She was admitted to the hospital on May the 6th in a very critical condition. There was no history of pregnancy and the physical signs pointed to an inflammatory mass filling the pelvis, an acute bilateral salpingitis. The patient was running a high temperature with a weak and rapid pulse. She was so depressed that it was deemed best not to operate until the following morning. Ice caps were placed over the lower abdomen and strychnia and morphia were given in full doses.

When placed on the operating table her condition was extremely critical. Stimulants and infusion of normal salt were given during anaesthesia. Physical examination under ether did not clear up the doubt as to the character of the intrapelvic mass. When the abdomen was opened the condition was manifest. The abdominal cavity was filled with masses of dark-colored clotted blood. The tube in the left side had ruptured from an early pregnancy, whilst the right tube was partially disorganized from an old salpingitis. I have never met as much free flow of blood in an abdominal cavity. It was apparently of some days' standing, as no leaking vessels were found. Before the operation was half completed the assistant remarked to me that the patient was apparently dying. I replied that I would complete the operation whether the patient was dead or alive, and as rapidly as I could finished the technique of the operation. When this was done and the condition of the patient was investigated, I agreed with my assistant that the patient's chances for living were poor indeed. Thanks to the patient and intelligent work of my assistants, Drs. Brent, Hammond and Mackall, the patient began to rally, and within 24 hours had fully recovered from shock. She then made a very rapid recovery.

I wish here to offer a few suggestions which may be helpful to younger surgeons. I have a number of times been told by the assistant that the patient was dead or dying on the table, to hurry up the operation or to sew up the incision before the operation was completed. Experience has shown me that it is better judgment to do a complete operation on a comparatively dying patient than to hurry to close the incision and leave behind conditions which will surely cause the death of the patient a few hours or few days later. I know I have saved a number of patients who were apparently dying on the table by following this rule.

It must be borne in mind that apparent shock is often due to profound anaesthesia. A broken down heart will often recover when the anaesthetic is withdrawn and powerful stimulation is used. This little line is worth remembering in surgery, as well as in its application to the many discouragements of life:

"Never give up; there are chances and changes
Helping the hopeful a hundred to one;
And through the chaos high heaven arranges
Ever success if you only hope on."

Conclusions.—Ectopic pregnancy is a much more common cause of intrapelvic disease than has been supposed.

Rupture of the tube from overdistension is the chief cause of intrapelvic hematocele. Primary rupture into the folds of the broad ligament occurs far more frequently than any other form of rupture, and is attended with less danger to the patient.

Tubal abortions are infrequent, but the death of the fetus at a very early stage of development may result in a hematoma of the tube or give rise to a hemato-salpinx, requiring a removal of the damaged tube.

Gonorrheal salpingitis is the most frequent cause of tubal gestation, and of early death of the embryo.

Tubal pregnancy is the common form of ectopic gestation and the primary stage of the abdominal variety.

The tubo-ovarian variety was found in one case of this series of 45 cases.

Ectopic pregnancy is a treacherous condition and should be arrested by an abdominal section as soon as it is recognized.

PRESIDENT'S ADDRESS AT THE MEETING OF THE MEDICAL ALUMNI ASSOCIATION.

By Thomas M. Chaney, M. D., *Chaney, Md.*

To the Alumni Association of the School of Medicine of the University of Maryland:

I thank you, gentlemen, for the honor you conferred upon me a year ago in making me President of this Association.

Every alumnus of the Medical School of the University should be proud of his relation to it. Back of him are one hundred years of useful work by the alumni of this school, throughout the world and especially in this State.

In my opinion this school has been the most useful educational institution that has ever existed in this State. It has done more than any other for the health, the comfort and well-being of the people of this State by sending out men equipped to give relief to the sick, men in advance of others in their communities in intelligence and morality, and men who by association with professors who had high ideals of their professional duties had gotten the best preparation possible for becoming useful and upright citizens.

There are no educational institutions in the State and few in the country that hold such a record as does this school. There are older schools in the State, but ours is the oldest medical school, and I claim that the services of a well prepared, conscientious physician are more important in a community than those of the best men belonging to any other profession.

For many years being the only medical school in the State, it supplied with physicians every part of this State and much of Virginia, the Carolinas and other Southern States. This is our record.

Many who attended our school years ago look back, and, recalling such names as McSherry, Aiken, Miltenberger, Smith, Chew and others, speak of that as the golden period of our school.

A few years ago, while living in the city, I had good opportunities for seeing the work in the different medical schools and hospitals of the city. I became convinced that this school is doing better work now than it has ever done at any period since I have been familiar with it, and that it is doing as good work as any other school in the city. As proof of this faith I offer my works. Two Chaney boys, a son and a nephew, have recently been added to the list of alumni of the school, and nearly or quite all persons who come from our part of the country to enter a hospital come to the University Hospital. In our part of the State—Calvert and lower Anne Arundel—physicians who graduated at other schools send their patients here. This is the best proof of the estimate placed upon the work of the men now in charge of the school and the hospital.

The future of the school is assured. There is no reason for alarm. We send no Jack Binns to send out C. Q. D. messages. But the competition between the medical schools of the city is greater than ever before. Here and throughout the country schools of all kinds are making changes with a view to improving their courses of study and giving better training to their pupils.

The formation of an advisory council is one that has already been started in connection with the University of Maryland. Another change from Provost to President. University of Virginia, Wm. Wirt, first elected to Presidency; then Dr. Alderman. But these subjects will be discussed by others. The one important question for us tonight is disbandment. However this may be, let us keep up our interest and return year by year, and as Antaeus become invincible by touching his mother earth.

REPORT OF COMMITTEES TO REGENTS OF UNIVERSITY OF MARYLAND ON REORGANIZATION OF UNIVERSITY MANAGEMENT, Etc.

To the Regents:

At our last meeting two committees were appointed, consisting of Professors Hemmeter, Poe and Ashby, and Professors Poe, Harlan and Coale, to consider a preamble and resolution adopted by the General Alumni Association of the University, suggesting the election of a paid provost or president, with a governing body independent of the teaching bodies, and to confer with the General Alumni Association as to the expediency of the establishment of an advisory council from amongst the

alumni to communicate with the Regents on problems of university administration.

Inasmuch as these two resolutions, while not identical, related to the same matter, the members of these two committees deemed it expedient to consider them jointly, with a view to the better understanding of the questions referred to them.

Having been formally advised of the appointment of a special committee of ten of the General Alumni Association, with instructions to present to the Regents a recommendation from the General Alumni Association looking to alumni representation in the Board of Regents, your committee invited this committee of ten to a conference, which was held at the office of Professor Poe on the 5th of May, instant.

At this conference the views of the committee of the General Alumni Association were presented and discussed; the text of the recommendation of the General Alumni Association was laid before your committees, and a full statement made of the views and wishes of the Alumni Association upon the whole subject.

Your committees have considered with some care the matters submitted to them, and the arguments of the Special Committee of Ten, and now present the conclusions which they have reached.

Upon an examination of the charter of the University, as contained in the Act of 1812, Chapter 159, your committees do not find any provision under which the recommendation of the General Alumni Association for the election from the alumni of five members to the Board of Regents could be validly accomplished.

Regents are authorized, and the mode of their appointment prescribed, for the several faculties which, by the charter, constitute the University, but we find no warrant for the introduction into the body of Regents of members not representing or professing to represent any one of these several faculties.

When it is borne in mind that of the present Board of twenty-three Regents fifteen are alumni, who, in their position as regents and as alumni, are thoroughly in touch with the alumni, and may well be understood to represent their views and wishes, it is not easy to see how the introduction into the Board of Regents of five new members selected from the great body of alumni, not engaged at all in the work of the University, can add to the vigor and efficiency of her work; and your committee, therefore, find no reason to regret that the provisions of the charter are not sufficiently elastic to lead us to accept the recommendation in this particular of the General Alumni Association; and more especially is this the case when it is further borne in mind that the policy of the several faculties is to fill vacancies in their number, as they occur, from amongst the best-equipped of our alumni.

While, therefore, we cannot recommend acceptance of this recommendation, we see no reasonable ground of objection to the plan recently adopted by the Johns Hopkins University looking to the selection of an advisory council of ten or fifteen from amongst the alumni, with whom, under suitable rules and regulations to be formulated by the Regents, consultations can be had relating to problems of University administration and education, and we are free to say that we would welcome the appointment of such an advisory council, and do not doubt that valuable assistance would be given to the general work of the University by suggestions and advice from time to time from such representatives of the alumni.

Your committee have also considered the subject covered by the preamble and resolution of the Alumni Association looking to the election of a paid provost or president.

The charter does not contemplate the performance by the provost of active administrative duties calling for constant attention or supervision, and entitling the incumbent of the office to compensation, but there is no prohibition against an enlargement of the duties which he is now performing, nor is there anything in the charter to prevent the Regents from affixing to the office of Provost a salary commensurate with the dignity of the position and the duties which, under proper rules and regulations, the Board of Regents are authorized to assign to him.

The practical difficulty in the way of fixing a large salary to his official position is that the University has no endowment out of which such compensation could come, and accordingly the only source from which such compensation could be derived would be an assessment made by the Regents upon the shares of the tuition fees respectively received by the

various members of our several faculties of instruction.

This, of course, would involve an annual reduction of the amount received by each professor, but we are sure that a moderate contribution will be cheerfully agreed to by all the members of our teaching faculties in order to secure a closer supervision of the details of our university work by our presiding officer than has ever been expected from him or his distinguished predecessor, if such additional supervision shall be deemed necessary for the progress of the University.

In answer to the suggestion of the General Alumni Association upon the subject, we recommend that it be at once taken into consideration by a special committee, to be appointed for the purpose, consisting of one representative from each of our five faculties, to report at our next regular meeting.

In connection with this question of the election of a paid provost, your committees have also considered the additional vague and indefinite recommendations of representatives of the alumni for a reorganization of the University by the creation of "a governing body of trustees independent of the teaching bodies."

The charter does not contemplate or warrant such a method of carrying on the work of the University, and so radical a change in our organization does not commend itself to our judgment.

It could not be made without a substantially new charter, and if this were obtained we do not perceive how the work which the University is now doing with such gratifying efficiency and success could be enlarged and improved under the direction of a board of trustees, none of whom would be members of our several teaching bodies.

To start with, there would be great difficulty in obtaining the services of public-spirited and properly qualified men who, without compensation, would give the necessary time and attention to the heavy and responsible labor of directing the administration of our several departments; nor can it be reasonably expected that our present force of professors would voluntarily relinquish their positions and turn over to an entirely new Board of Trustees complete control of the affairs, property, resources and revenues of the University.

Moreover, there is the initial and apparently insuperable difficulty in determining how and by whom this new Board of Trustees are to be selected.

The small number of alumni from whom comes this request for the destruction of our existing organization do not suggest any way of solving this difficulty.

If, however, these practical obstacles could be surmounted; if our present Board of Regents were to step down and out; if we had a new Board of Trustees clothed with full authority to administer the work of the University in its several departments, with a paid Provost or President receiving a fairly large salary out of a fund yet to be raised in the distant future, what reason is there to believe that we would have an increase in the number and quality of our students, or more efficient, thorough and successful teaching?

In short, what better results can be looked for from a new governing body and a new faculty of instruction for each of our several departments than we have now?

Viewing this subject in every respect, we fail to see the benefits that would accrue to the University by annulling our present charter and taking a leap in the dark.

As embodying our conclusions we submit the following resolutions:

Resolved, That the Secretary be, and he is hereby, instructed to report to the Committee of Ten of the General Alumni Association that the Regents have carefully considered their recent communication proposing the election by the alumni of five representatives of the alumni, none of whom shall be full professors, as additional members of the Board of Regents, and that, upon an examination of the charter, the Regents find no warrant for such an addition to their members; nor are the Regents inclined to recommend to the General Assembly an amendment to the charter authorizing this proposed change in the organization of the Board of Regents.

Resolved, further, That the Regents approve the election by the alumni of an Advisory Council, empowered to present from time to time to the Regents their views and wishes, and assure the Association of Alumni that the Regents will gladly welcome and always carefully consider suggestions and recommendations emanating from such Advisory Council.

Resolved, also, That the Secretary report further to the Alumni Association that their suggestion with reference to the payment of a salary to our Provost is now under consideration by the Regents, and shall be acted upon at an early date; and further, that the Regents see no reason for a reorganization of the University by "the creation of a governing body of trustees independent of the teaching bodies," and are, consequently, opposed to an amendment of the charter of the University in order to accomplish this suggested reorganization.

JOHN PRENTISS POE,
HENRY D. HARLAN,
R. DORSEY COALE,
THOMAS A. ASHBY,
JOHN C. HEMMETER,
Committee.

May 26, 1909.

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EDITORIAL.

THE RECENT COMMENCEMENT AT THE UNIVERSITY OF MARYLAND.—On May 31st, in the Academy of Music, the annual commencement of all of the Departments of the University of Maryland was held in the presence of a large and brilliant audience. The occasion was a most impressive one and the exercises were most inspiring. Degrees were conferred upon 237 students, the Medical Department leading with 89 graduates.

THE BULLETIN takes pleasure in referring to the work of all the Departments of the University which gives evidence of growth and improvement during the past year. The joint commencement of the Departments, the splendid classes of young graduates and the combined interests of the Faculties in the educational work of the University, all show the continued growth of the University spirit and the progress which the University is making in the educational world. The man who fails to see the substantial gains which each Department of the University is making from year to year is a pessimist of deepest prejudice. The true friends of the University, who see facts in their proper light, must realize that this continued cry for radical changes in University management, for sudden upheavals of traditions and policies in its government, are not fully warranted at the present time.

Every thinking mind knows full well that all methods may be improved under proper conditions. The work now carried on by each Department could be materially improved were conditions more favorable for radical reforms in policies and methods of government. With plenty of money and practical leadership it might be possible to bring about the changes which some of the optimistic friends of the University have so earnestly advocated. At the present time the University has neither plenty of money nor can she command that practical leadership which is so necessary to guarantee success in a departure so radical as has been proposed.

In the present Board of Regents the alumni of the University are liberally represented. We cannot believe that a Board of Trustees composed of men who are not connected with the different Faculties could, without a large endowment, conduct the work of the University to better advantage to the University than the present Board of Regents, now so largely interested in the work of the different Departments. It would be well for those who are so active in urging radical departures from present methods of government to think well and wisely. Are the changes which they propose practical or rational at this time? Is it not more rational to assume that results will follow through gradual steps rather than by a sudden leap into the dark, which would most probably plunge the University into a whirlpool of disaster?

In the world of education as in the world of commerce and trade, revolutions are most usually disastrous. The law of progress is grounded on established principles. Results only follow rational and definite lines of action. The future growth of a greater University of Maryland must come through gradual steps, through practical and conservative lines of policy, not by uprooting the great system of a century's growth by violence and planting a lot of saplings which may never flourish. The men who now govern the affairs of the University are as jealous of her interests and are as anxious to enlarge her sphere of influence and usefulness as any of her alumni. They will not be diverted from their sense of duty to the University by spurious arguments or fanciful reasonings. As facts evolve they are prepared to grasp them, and as conditions warrant methods and policies will be adjusted to meet them.

RESIGNATION OF PROF. SAMUEL C. CHEW.—The alumni of the University of Maryland will learn with profound regret that Professor Chew has resigned the chair of Professor of Medicine, which he has filled for so many years with rare grace, efficiency and distinction. Professor Chew was elected to the chair of Materia Medica and Therapeutic in 1864. Upon the retirement of Prof. Richard McSherry from the Faculty of

Physic in 1885, Professor Chew was elected to the chair of Principles and Practice of Medicine, which he has held until the present time with the recent change of the title of the chair, at Professor Chew's request, to Professor of Medicine. Professor Chew's service in the Faculty of Physic has exceeded in number of years the service of any one who has held a chair in the Faculty of Physic. It is but proper to say that no one who has ever filled a chair in the University has rendered a more loyal, valuable and popular service to the institution than has Professor Chew. His varied accomplishments as a teacher, his urbanity, dignity and pure character, his splendid influence over the student body and over the alumni, and his exalted position in this community as a gentleman of the highest culture and refinement, are distinctions which it is permitted to few men to reach in any calling in life.

We say it without hesitation that no man connected with the Faculty of Physic has ever been more beloved and esteemed by his associates in the educational work of the University than has been Professor Chew. His retirement from the active work of the chair he has so long graced has brought deep sorrow to his colleagues. We are happy to know, however, that as Emeritus Professor of Medicine we shall retain his deep and abiding interest in and loyalty to the old University. We wish many years of health and happiness to him in his retirement and pray reverently that the Giver of All Good will grant to him the satisfaction and rewards which should come from a life's work so given up to the highest aims and ideals of service to his fellow-man.

Commencement Exercises and Degrees Conferred.—Degrees were conferred upon 237 graduates in the arts and sciences, medicine, law, denistry and pharmacy at the annual commencement of the University of Maryland at the Academy of Music, Monday, May 31, 1909. Among the graduates were three young women, one in dentistry and two in pharmacy. Five honorary degrees were also conferred.

Among those upon whom honorary degrees were conferred were Chief Judge Andrew Hunter Boyd, of the Court of Appeals, and Dr. John Allan Wyeth, of New York, who delivered the address to the graduates.

In presenting the name of Chief Judge Boyd for the degree Mr. John P. Poe, Dean of the University, said:

"One of the most gratifying facts in our Maryland history is that the chief justices of our Court of Appeals have always been men of pre-eminent professional distinction. In casting our eyes over the list of those who from the foundation of the court down to the present time have presided over its deliberations the record shows that its chiefs have invariably been learned, laborious, discriminating, always uniting attractive clearness of statement with convincing strength of reasoning in their judicial opinions.

"Proudly rejoicing in the fame of those who in their exalted position led the court for many past generations in the administration of a pure and enlightened justice, we of this generation are equally proud to know that our present chief, Andrew Hunter Boyd, maintains the high rank of his distinguished predecessors in the commanding qualities and endowments which, in symmetrical proportions, give us the lofty measure of a most accomplished and honored judge and gentleman.

"His work for 16 years upon the bench, following a deservedly successful career at the bar, justly entitles him to public admiration and praise, and I count it a high privilege to be commissioned by the Regents of the University to present him to you for the honorary degree of Doctor of Laws."

Another honorary degree conferred was that of Doctor of Divinity upon Rev. John Timothy Stone, formerly pastor of Brown Memorial Church. Mr. Stone was not present. His name was presented by Judge Stockbridge.

The other honorary degrees conferred were those of Master of Arts upon Mr. Isaac Brooks, Jr., and Doctor of Sciences upon Dr. Rupert Lee Blue, of the Marine Hospital Service in San Francisco.

Mr. Bernard Carter, Provost of the University, conferred the degrees, the candidates for which were presented by the Deans of the respective faculties. Dr. Wyeth spoke mainly to the graduates in medicine, being better acquainted, as he said, with what was required of that profession. A clean, healthy life, sobriety and self-control, he said, are most essential to the physician. As the greatest work of the physician is to prevent, rather than to cure, diseases, he also said, he thought the ideal lawyer is one who will settle disputes, rather than promote litigation.

After Dr. Wyeth's address the names of the graduates were called, and they went upon the

stage and received their diplomas. Dr. Thomas Fell, of St. John's College, which is a part of the University, presented the candidates for the degree of Bachelor of Arts and Bachelor of Sciences. Dr. R. Dorsey Coale presented the candidates for the degree of Doctor of Medicine; Mr. John P. Poe, the candidates for the degree of Bachelor of Laws; Dr. Ferdinand J. S. Gorgas, the candidates for the degree of Doctor of Dental Surgery, and Dr. Charles Caspari, Jr., the candidates for the degree of Doctor of Pharmacy.

The names of the graduates are as follows:

Bachelor of Arts (all from Maryland)—Lloyd C. Bartgis, J. Irvin Dawson, J. Alexander Kendrick, Arthur Rufus Laney, Harrison McAlpine, Allan H. St. Clair, Edwin Warfield, Charles L. Weaver and Frank H. Gauss.

Bachelor of Sciences (all from Maryland)—William B. Ennis, Clarence T. Johnson, R. Elmer Jones and Albert Knox Starlings.

DOCTOR OF MEDICINE.

Maryland—Clarence Irving Benson, William Ward Braithwaite, Norman Irving Broadwater, Arthur Louis Fehsenfeld, Harry Baldwin Gantt, Jr., Morris Baldwin Green, Joseph Ward Hooper, Samuel Herman Long, James Finney Magraw, William E. Martin, James Wm. Meade, Jr., Wilmer Marshall Priest, William Gwynn Queen, Louis Hyman Roddy, John T. Russell, John G. Schweinsberg, Reed A. Shankwiler, Claude C. Smink, Maurice Isaac Stein, Frederick Henry Vinup and Walter Franklin Weber.

Virginia—Carroll Augustus Davis, Julian Mason Gillespie, Preston Hundley, Joel Cutchins Rawls, John William Robertson, Hugh W. Smeltzer, Charles Franklin Strosnider and Eugene Bascom Wright.

West Virginia—William John Blake, Simon Wickline Hill and John Nelson Neill Osburn.

North Carolina—Darius Cleveland Absher, Branch Craig, J. Ernest Dowdy, Edgar Miller Long, Ross Simonton McElwee, John Sanford Mason, James Leftwich Moorefield, John Standing Norman, Lytle Neal Patrick, Frederick Wharton Rankin, Neale Summers Stirewalt, Charles LeR. Swindell, Asa Thurston and John Bruce Weatherly.

South Carolina—Maxey Lee Brogden, Paul Brown, Arthur E. Cannon, William Thornwell Gibson, Everette Iseman, Thomas Alexander Patrick, Furman Thomas Simpson and T. Hayne Wedeman.

New York—William S. Campbell, Edwin B. Goodall, Harry M. Robinson and R. Gerard Willse.

New Jersey—Charles Herbert Johnson, William Walter Kettele and Budd Jameson Reaser.

Canada—A. Marvin Bell and Ralph Norvel Knowles.

Ohio—George E. Bennett.

Florida—Clarence Bythell Collins, James P. Parramore and Adam Clark Walkup.

Georgia—Robert H. Gantt, Benjamin Harrison Gibson and Lehmon W. Williams.

Rhode Island—Howard Barton Bryer.

Massachusetts—Arthur Judson Cole and Alfred Chase Trull.

Pennsylvania—Thomas Robert Dougher, James A. Hughes, Adam Seanor Kepple, John Lindsey Messmore, Charles A. Neafie and J. W. Ricketts.

Delaware—George Edward James.

Minnesota—Howard Kerns.

Nebraska—Cleland G. Moore.

California—Samuel Jackson Price.

Iowa—Lynn J. Putman.

Cuba—Miguel A. Buch y Portuondo.

Porto Rico—Jose Y. de Guzman Soto.

England—Thomas Gilchrist.

Syria—Jemil Abdallah el Rassy.

These appointments were made to the University Hospital:

Resident Physicians—Joseph L. Hooper, W. H. Queen and J. L. Robertson.

Resident Surgeons—G. H. Richards, T. M. West, N. Irving Broadwater, Frederick Rankin and James S. McGraw.

Resident Gynecologists—J. S. Wilsie and C. C. Smink.

Resident Pathologist—J. W. Ricketts.

Resident Obstetricians—A. H. Hughes, John N. Osborn and C. C. Cannon.

Resident Physicians at Bayview—Branch Craig, J. S. Norman and H. B. Gantt, Jr.

RELIEF FUND FOR DR. JAS. CARROLL'S FAMILY.—It has been suggested by some of the alumni of the University of Maryland that THE HOSPITAL BULLETIN should attempt to raise a special contribution to the "Relief Fund for Dr. James Carroll's Family," now being raised by the Journal of the American Medical Association. THE BULLETIN will cheerfully forward all contributions made through it to this fund. Any of the alumni of the University who desire to contribute to this fund can do so by forwarding their contribution direct to the Journal of the American Medical Association or through THE BULLETIN. The following letter from Dr. S. W. Hammond, class 1905, explains the situation:

"I would beg to invite your attention to the call made on the medical profession for 'Relief of Dr. Carroll's Widow'—Journal American Medical Association, April 3rd, page 1122, also editorial in same issue. I want to contribute to that fund, and feel that every alumnus of the University of Maryland would be glad to contribute. Dr. Carroll had the honor of being an alumnus, and none the less the U. of M. has the honor of being Dr. Carroll's alma mater. It occurs to me that it is a rare opportunity for our alma mater, through the alumni, to show her appreciation in a substantial way.

"The idea is to get up a fund, say in the name of 'Alumni University of Maryland.' It will do the old University good. Not that we would be acting Pharisee, but fulfilling that holy injunction to 'let your light so shine,' etc. And as an afterthought, there might as a result be established a precedent that, should any alumnus of the University of Maryland who has devoted his time, talent and energies unselfishly to the advancement of science and the protection of the life and health of humanity, such an one would feel encouraged in his altruistic efforts. I believe that a large number of the alumni can be reached through THE HOSPITAL BULLETIN. Details for ways and means for conducting the campaign through THE BULLETIN I, of course, leave to be worked out by those in charge, except to say that we can make our contributions for this fund, Relief of Dr. Carroll's Widow, etc., to THE BULLETIN, and the amount be turned over to the proper authorities as a whole, as above indicated. You will note in the Journal American Medical Association that all contributions are publicly acknowledged in its columns. I don't think we crave any self-aggrandizement by seeing our individual names set opposite our respective amounts contributed, but would like to see our old alma mater do her maternal duty and get the honors she deservedly merits."

RESOLUTIONS TO PROF. CHEW.—In consideration of the long and distinguished services rendered by Professor S. C. Chew, and as an evidence of the esteem and affection held for him by his colleagues of the Faculty of Physic, all of the members of the Faculty in the city visited Prof. Chew at his beautiful home, in Roland Park, on the afternoon of June 4th, and presented to him through their chairman, Prof. C. W. Mitchell, the following resolutions.

Professor Mitchell, in presenting these resolutions, made the following remarks:

"We all feel, dear Dr. Chew, that something more than words of formal resolution should be said on this occasion. We come rather as medical children to a beloved father to tell once more our story of gratitude and love, and to seek counsel and advice. Your resignation severs the last link that binds the majority of us to our former teachers, and we are loth to give you up. We want to maintain the high traditions which you for so many years have typified. We still want to breathe in your spirit. In our sadness we have the one consolation that in this beautiful library and home you have the solace of the world's best thought, the joy of religion, and the loving care of a devoted family."

WHEREAS, We, the members of the Faculty of Physic, University of Maryland, have received with profound sorrow the resignation of our revered and beloved colleague, Prof. Samuel C. Chew, and whereas his long service has been marked by ripe scholarship, high intellectual ideals, rare charm and grace of spoken and written word, didactic and clinical teaching of singular power and effectiveness, and by a pervasive moral force that quickened and refined all whom it touched;

Be it Resolved, That we accept the resignation of Prof. Chew with great regret and with the deepest feelings of esteem, affection and gratitude; and be it further

Resolved, That we wait upon Prof. Chew in a body to personally extend these resolutions to him, to request that he accept the title "Emeritus Professor of Medicine," and to express the hope that his remaining years may be spent in comfort and happiness and with the satisfaction which comes from a long life of high purpose and great achievement. Be it further

Resolved, That an engrossed copy of these resolutions be forwarded to Prof. Chew, signed by every member of the teaching staff of the University.

ALUMNI DAY.

Many of the representative medical schools are setting aside a day—Alumni—during their commencement exercises on which past graduates are invited to return and renew their allegiance to their Alma Mater. In order to make the visit profitable, instructive and sociable, various clinics are held, in the specialties as well as in general medicine and surgery; the buildings are inspected and class and general reunions held. It is the plan of Jefferson Medical College of Philadelphia, Pa., to celebrate such a day June 7, 1909. A like celebration by the University of Maryland would be a step in the right direction. We are doing a magnificent work of which many of our alumni are unaware. Indeed a large proportion of our graduates after commencement day never re-enter the portals of their Alma Mater, consequently they have no first-hand knowledge of what we are doing or have accomplished since they left us. If we can provise means for bringing them back, perhaps they will feel more kindly disposed to us. An Alumni Day would do much to accomplish this; at any rate Buffalo University, Harvard University, University of Pennsylvania and Jefferson Medical College think so. Surely they would be surprised at the quality and diversity of our work. If we had a president, this is one of the first matters he would take up, and shows our crying need for a directing force.

ITEMS.

At the annual meeting of the Medical and Chirurgical Faculty, held at their new building, 1211 Cathedral street, the following of our alumni were elected to office for the ensuing year: President, Dr. G. Milton Linthicum, M. A., Department Arts and Sciences, St. John's College; vice-president, Dr. Compton Riely; member of the Board of Trustees, Dr. D. E. Stone, class of 1864, Mt. Pleasant; councillors, Dr. Guy Steele, Cambridge; State Board Medical Examiners, Dr. Lewis B .Henkel, Annapolis; Dr. Herbert Harlan is president of the Board of Medical Examiners and Dr. W. W. Goldsborough is a member; delegates to American Medical Association, Dr. S. T. Earle; Committee on Scientific Work and Arrangements, Dr. A. M. Shipley; Library Committee, Dr. J. W. Williams; Committee on Public Instruction, Drs. M. C. Cromwell, Eugene Kerr; Committee on Widows and Orphans, Drs. E. F. Cordell, Theodore Cooke, Sr.; Memoirs Committee, Drs. J. T. Smith, G. H. Cairnes; Committee on Medical Education, Dr. Randolph Winslow; Sanitary and Moral Prophylaxis, Dr. O. E. Janney; Committee on Tuberculosis, Drs. P. Travers, R. B. Norment; Committee on Pure Food, Dr. N. R. Gorter.

Dr. Wm. T. Watson, of Baltimore, sailed June 3 on steamer Bremen, and will spend the summer in Germany.

Mrs. Warren Grice Elliott has sent out invitations for the marriage of her daughter, Elizabeth Preston, to Dr. Gordon Wilson, on Saturday, June 5, at 6 o'clock, at St. Paul's Church, Baltimore.

Dr. and Mrs. John C. Hemmeter have taken a cottage for the summer season at Portland, Me.

Dr. Rankin, Dean of the Wake Forrest College, North Carolina, recently spent a few days in Baltimore.

Mrs. Walter Levy, wife of Dr. Walter V. S. Levy, is a patient in the University Hospital.

Dr. and Mrs. Tunstall Taylor will spend the summer at Blue Ridge Summit.

The Hospital for the Women of Maryland, among other improvements, will dedicate operating rooms to the memory of Dr. W. T. Howard and Dr. H. P. C. Wilson.

The sixty-third annual commencement of the Medical Department of the University of Buffalo was held May 28, 1909. Alumni Day was celebrated with appropriate ceremonies May 25, amongst which were special clinics for the alumni visitors. This event seems to be a fixed feature of the Northern colleges. We could imitate them with profit both to ourselves and our visitors.

Dr. John C. Hemmeter, professor of physiology in the University of Maryland, has been named as one of the committee of patrons for the dedication of a monument to Michael Servetus, in Vienne, near Lyons, France, August 14, 1909.

Dr. Julian W. Ashby, of Carbon, W. Va., recently spent a few days' vacation in Baltimore.

Dr. G. B. Harrison, of Hot Springs, Va., recently paid a hurried visit to Baltimore.

Dr. and Mrs. D. M. Culbreth will spend the summer sojourning in the North.

Dr. and Mrs. Wm. H. Baltzell will occupy their summer home, Elm Bank, Wellesley, Mass., for the summer months.

Dr. and Mrs. Nathan R. Gorter will summer at the Chattolanee, Green Spring Valley, Md., where Dr. Gorter is the resident physician.

Dr. Eldridge C. Price, class of 1874, of Baltimore, read a paper on "The Imminent Danger of Extinction Which Threatens the Homeopathic School in the State of Maryland as a Distinctive Branch of the Medical Profession; and the Remedy," before the annual meeting of the Maryland State Homeopathic Medical Society.

Dr. Charles H. Riley, class of 1880, delivered the graduation address to the nurses of the Shepperd and Enoch Pratt Hospital School for Nurses. Dr. Riley is vice-president of the trustees.

At the commencement of the University of Maryland, held at the Academy of Music May 31, the honorary degree of LL. D. was conferred on Chief Judge Boyd, of the Maryland Court of Appeals, and Dr. John A. Wyeth, of New York, who delivered the address to the graduates. Dr. Wyeth is well known as a Confederate soldier and historian, as well as for his surgical writings.

Dr. Louis Seth, assistant physician at Sabillasville, has been spending a few days in Baltimore. He is looking hale and hearty, and reports that he never felt better in his life. His looks do not belie him. We are glad to report that he has made such rapid strides toward the regainal of his health.

Dr. A. A. Matthews, class of 1900, of Spokane, Wash., who has recently been quite ill with grip, we are glad to report to his friends has entirely recovered.

Dr. George C. Winterson, class of 1902, has located at Red Cloud, Nebraska. The reports are that he is succeeding in building up a nice practice.

Drs. Charles W. Famous and Walter T. Messmore, both of the class of 1901, attended the banquet.

Dr. James P. Parramore, class of 1909, has received an appointment as assistant resident surgeon at St. Joseph's Hospital, Baltimore.

Dr. Silas Baldwin, 700 West Lafayette avenue, Baltimore, was thrown to the ground and injured while driving in Druid Hill Park, May 30, 1909.

Dr. Samuel J. King, class of 1902, of Baltimore, will leave during the latter part of June to locate at Winnemucca, Nevada.

Dr. J. C. Robertson, class of 1900, who has been quite ill, is reported to be improving.

E. P. Tignor, D. D. S., M. D., relieved from temporary duty at Fort Monroe, will proceed to Fort Slocum, New York.

Dr. E. F. Cordell delivered addresses before the District of Columbia Branch of the General Alumni Association at Washington, April 29, and the Pennsylvania Branch at York, May 1.

The annual meeting of Baltimore County Medical Association was held in Towson, May 20. Dr. Bennet F. Bussey, 1885, Cockeysville, was elected president; Dr. Richard C. Massenburg, Towson, corresponding secretary; Dr. Josiah S. Bowen, Mount Washington, recording secretary, and Drs. H. Lewis Naylor, Pikesville, and L. Gibbons Smart, Lutherville, were elected delegates to the Medical and Chirurgical Faculty of Maryland.

Dr. Charles Franklin Strosnider, class of 1909, has been appointed assistant superintendent of the James Walker Memorial Hospital, Wilmington, N. C.

Dr. Martin L. Jarrett, class of 1864, of Baltimore, was recently elected commander of the James R. Herbert Camp, United Confederate Veterans.

The following of our alumni are connected with the Northeastern Dispensary, according to their Fifty-sixth Annual Report: Secretary, Dr. A. D. McConachie; executive committee, Dr. A. D. McConachie; directors, Dr. George A. Hartman, Dr. A. D. McConachie; general medicine, Dr. P. E. Lilly, class of 1901; diseases of children, Dr. A. L. Levy; nose and throat, Dr. J. C. Robertson; eye and ear, Dr. A. D. McConachie; eye and ear, Dr. J. S. Bowen; skin, Dr. Fred Wilkins; chief of outdoor clinic, Dr. P. E. Lilly.

The following of our alumni are connected with the South Baltimore Eye, Ear, Nose and Throat Charity Hospital: Consulting medical and surgical staff, Dr. Samuel Theobald, Dr. Hiram Woods, Dr. J. Frank Crouch, Dr. Chas. O'Donovan; assistant surgeon, Dr. J. F. Hawkins.

Dr. N. G. Keirle is director of the Pasteur Institute, College of Physicians and Surgeons; Dr. Charles F. Bevan, class of 1871, is dean of the same school.

Dr. and Mrs. L. Ernest Neale will go to Ocean City for the summer.

Dr. G. Milton Linthicum, the new president of the Medical and Chirurgical Faculty, is an alumnus of the University of Maryland, having obtained a portion of his collegiate education at St. John's College, our department of arts and sciences.

Drs. T. A. Ashby and Charles O'Donovan made addresses at the annual meeting of the Medical and Chirurgical Faculty; Dr. H. O. Reik made the report of The Bulletin committee; Dr. J. L. Hirsh read a paper on "Family Epidemic of Acute Trichiniasis;" Dr. F. J. Kirby read a paper on "Tumors of the Carotid Gland, Report of a Case;" Dr. H. O. Reik, "An Atlas of Otology, Illustrated by the Epydiascope;" Dr. G. Timberlake, "Demonstration of Spirochetae Pallida by Dark Field Illumination;" Dr. R. H. Johnston, "Direct Laryngoscopy."

At the meeting of the Anne Arundel County Medical Society, held April 16, at the Hotel Maryland, Annapolis, Dr. F. H. Anderson, class of 1870, read a highly instructive and interesting paper on "The Treatment of Typhoid Fever." Among those present were Drs. H. B. Gannt, Millersville; C. R. Winterson, Elkridge; L. B. Henkel, Annapolis; J. S. Billingslea, Armiger.

Dr. J. R. Downs, class of 1904, is secretary of Caroline County Medical Society.

At the regular meeting of the Howard County Medical Society, held at the Howard House, Ellicott City, April 6, 1909, our alumni were elected to the following offices for the ensuing year: President, Dr. T. B. Owings, class of 1852; vice-president, Dr. Wm. R. Eareckson. Dr. F. O. Miller was appointed one of a committee to secure a permanent meeting place. Dr. Frank Janney addressed the society on the aural complications most frequently met with following grip.

Dr. Samuel T. Earle will read a paper on "A Review of Proctologic Literature for 1908" at the coming meeting of the American Proctologic Society, to be held at Atlantic City, June 7, 1909; also a paper on "Tubercular Fistula with Extensive Infiltration, with Specimen Exhibited." Dr. J. Rawson Pennington, class of 1887, of Chicago, "Further Observations in the Use of Bismuth Paste in the Treatment of Rectal Fistula."

Dr. S. R. Donohoe, class of 1902, of Norfolk, Va., writes: "Two men of the class of 1905—H. E. Jenkins and W. J. Riddick—have passed the examination for the Medical Department of the United States Navy. They stood the examination in Washington last week, and among a number of applicants were the only successful candidates. Things of this sort mean something for the old University. We all take pride in the success of the alumni, and their friends will be glad to hear of their good fortune." The editors desire to take this occasion to congratulate both Drs. Jenkins and Riddick on their successful accomplishment of a task and attainment of a position desired by many, but actually realized by less than 20 per cent. of those taking the examinations. It is such men as these that reflect credit upon those who have taught them and their alma mater.

We have heard that Dr. A. D. Tuttle, class of 1906, a veteran of the Filipino and Chinese Wars, and withal a good fellow and student, has successfully passed the Army Medical Examining Board and is now a first lieutenant in the Medical Corps, United States Army. We also extend to Dr. Tuttle our congratulations upon his success, and hope that if the occasion offers he will shed as much lustre upon his school as Carroll and Victor Ruppert Blue.

Commencement exercises took place at St. John's College (Department Arts and Sciences), Annapolis, June 11 to June 16. Of particular interest was the celebration of the one hundred and twenty-fifth anniversary of the chartering of St. John's College as a collegiate institute. St. John's was founded as King William's School in 1689, and in 1784 it was merged into St. John's College. Only Harvard, at Cambridge, Mass., and William and Mary, at Williamsburg, Va., antedate St. John's in their beginnings as institutions of learning.

The exercises commemorative of the founding of the college will take place on Wednesday, June 16, the same day that the class graduates. Over 50 of the leading institutions of learning of the country will be represented by their presidents or prominent members of the faculty or alumni. The list includes all of the institutions in this vicinity, with most of the others throughout the country which are notable for their historic interest or on account of their prominence in the intellectual life of the nation.

About 15 graduates will receive degrees of bachelor of arts and bachelor of science, while a number of distinguished alumni and others will receive honorary degrees, among whom is Dr. Randolph Winslow, who receives an LL. D.

Dr. Taylor E. Darby, class of 1904, is located at Barnesville, Montgomery county, Md.

Dr. C. Urban Smith is connected with the Faculty of the Maryland Medical College.

Dr. Louis H. Seth, formerly assistant resident physician in the hospital, is at present assistant resident physician in the Tuberculosis Sanitarium, Sabillasville. Dr. John C. Hemmeter delivered the address of the occasion to the graduates of the Hebrew Hospital Training School for Nurses. Amongst others who spoke were Drs. J. L. Hirsh and Harry Adler, who, with a few appropriate words, distributed the diplomas.

Dr. and Mrs. Eugene Raphel, of Wheeling, W. Va., have been the guests of Miss Edgarina Hastings, niece of Judge Martin Morris, with whom she makes her home at 1314 Massachusetts avenue, Washington, D. C.

Dr. Robert W. Crawford, class of 1906, of Rocky Mount, N. C., paid the city and the University Hospital a visit recently.

Dr. James Taylor, of North Carolina, recently stopped at the University Hospital.

Mr. and Mrs. Alfred Courtney Doyle, of The Hylands, Walbrook, have announced the engagement of their daughter, Agnes Hegg, to Dr. John Wilson MacConnell, of Davidson, N. C., formerly resident physician at the Presbyterian Eye, Ear and Throat Hospital, Baltimore.

The residents and graduating class of the University of Maryland Medical School recently gave a farewell dance at Albaugh's Theatre in honor of the nurses of the University Hospital. Among those present were: Misses Wilson, Wright, Israel, Chapline, Almond, Ely, Barrett, Murchoin, Robey, Tess, Salisbury, Garrison, Tull, Kimmel; Drs. Bird, Hammond, J. H. Bay, Kolb, Coleman and West; Messrs. Hooper, Wright, Gannt, Queen, Broadwater, Ricketts, Moorefield, Brown, Mason, Osborn and Kirk.

A memorial service was held at Central Young Men's Christian Association for Dr. E. T. Duke.

Dr. G. B. Harrison is superintendent of the Green Brier General Hospital, Ronceverte, W. Va.

Dr. Hiram Woods presided at the second annual meeting of the Maryland Society of Social Hygiene.

The annual reunion of the Medical Alumni Association of the University of Maryland and banquet were held at the Eutaw House, Baltimore, Md., Monday night, May 31, 1909. At the business meeting Dr. Thomas M. Chaney, the president presided, and in the absence of Dr. Sadtler, the secretary, Dr. James M. Craighill acted pro tem. Several new members were elected to membership. Dr. Cordell reported that the endowment fund now amounted to a little over $19,000. A few reminiscent remarks were indulged in by Drs. Cordell, Taneyhill and Ashby. A motion to disband the association and amalgamate with the General Alumni Association was proposed, but defeated. This motion brought forth a heated discussion, both pro and con.

Officers for 1909-10 were elected as follows: President, Wm. H. Pearce, M. D.; vice-presidents, Guy Steele, M. D., Joseph Smith, M. D., A. C. Pole, M. D.; recording secretary, Charles E. Sadtler, M. D.; assistant recording secretary, J. F. H. Gorsuch, M. D.; corresponding secretary, John Houff, M. D.; treasurer, John I. Penington, M. D.; executive committee, A. D. McConachie, M. D., Geo. H. Hocking, M. D., C. A. Winterson, M. D., B. M. Hopkinson, M. D., G. Lane Taneyhill, M. D.

The banquet was enlivened by solos by Dr. B. Merrill Hopkinson and Mr. Lynn Hobart. During the courses Hesse's Orchestra dispensed music. About 150, including the graduating class, which was the guest of the medical faculty, were present.

Dr. A. E. Landers is located at Crumpton, Md.

Dr. K. M. Jarrell, class '06, is now practicing in Clear Creek, W. Va. Dr. Jarrell writes that he has built up a large practice and is having fine success. He has recently been appointed health officer for Raleigh county, W. Va., for four years, with a fair salary attached. He expects to visit Baltimore during the present month.

Dr. J. A. Devlin, class of 1906, writes in part: "I am sending you a copy of the report of St. Francis Hospital, of which I am now house surgeon. I should have been in this illustrious position a year ago, but spent most of the year of 1907 in bed, the rest in sulphur baths at Richfield Springs. I had acute articular rheumatism and the trimmings on the endocardium which go with it. Altogether had a very nice party. I resumed my work here January 1st, 1908. I get THE BULLETIN regularly, and it is very interesting to me. I often wish I could stop work for a while and pay a visit to you all, and perhaps aid in coaching a team (football) to beat Hopkins.

DEATHS.

Dr. Benjamin F. Lansdale, 64 years old, for 40 years a practising physician at Damascus, Md., died May 21, 1909, at his home, in Damascus, of cancer of the stomach. Surviving him is a widow, who was a daughter of the late Philemon M. M. Smith, of Gaithersburg, and three children—Dr. P. Smith Lansdale, of Ohio; Mrs. John Lewis and Mrs. Beall, of Damascus. Dr. Lansdale was born in Washington and was a son of the late Henry Nelson Lansdale, of that city. He was educated in Washington and Baltimore, and was graduated from the University of Maryland, class of 1866, beginning the practice of his profession soon afterward.

Dr. Willis Alston, class of 1869, a member of the Medical Society of the State of North Carolina, and one of its founders, for six years a member of the State Board of Medical Examiners, died at his home, in Littleton, April 20, 1909, aged 62.

Dr. Charles W. Harper, class of 1869, one of the best-known residents of Halethorpe, Md., died May 14, 1909, at his home, from infirmities of old age. Dr. Harper was about 70 years old and had practiced medicine in Halethorpe many years. He is survived by his wife.

Dr. John Kilgour White, class of 1884, of Woodland, Md., died suddenly from pneumonia April 4, 1909.

Dr. Roger Brooke, class of 1887, of Sandy Springs, Md., 62 years old, for many years a leading physician, died May 9, 1909. He had an attack of acute indigestion about April 1, and this developed into a heart weakness which caused his death.

Dr. Brooke was highly regarded for skill and faithfulness in practice. He participated in all public-spirited enterprises, being a most active spirit in the organization of the Enterprise Telephone Company, a local corporation, and was its president and general manager for several years, and was president at the time the company was sold to the Chesapeake and Potomac Company a few years ago. At the time of his death he was a member of the committee having in charge the construction of the high school building here. The good-roads question interested him deeply, and he earnestly participated in every effort directed toward abolishing tollgates. He was an active member of Montgomery County Medical Society and had served as its president.

Surviving him are his widow, Mrs. Louisa T. Brooke, and five children—Mrs. Emilie B. Coulter, Miss Sallie Brooke, of Sandy Spring; Mrs. N. G. Smith, of Auburn, Me.; Dr. Roger Brooke, an army surgeon, and Edward T. Brooke.

The funeral took place May 11, 1909, from the family residence, and was attended by one of the largest gatherings ever seen at a funeral in that section of the county. The services were those of the orthodox branch of the Society of Friends, of which Dr. Brooke was a prominent member. Walter Brooke, Caleb Stabler, Tarlton Brooke and Fred L. Thomas, nephews of Dr. Brooke, and Joseph Janney and Dr. George E. Cooke were the pallbearers. The interment was in Woodside Cemetery, near Ashton.

Oh, why has worth so short a date? It is only the loss of such a man as Roger Brooke that can teach his mourners—who comprise all who knew him—what was his real value to the people among whom he lived. It is no disparagement to those who are left to say that there is no other person in the entire neighborhood who could so ill have been spared. As a citizen he performed his full duty, taking a prominent part in measures for the benefit and uplift of the community; as a man he won the respect and warm friendship of a large circle, always being guided by what he believed to be right; as a husband his life for nearly forty years was the highest type and example of consistent devoted love; as father and grandfather he combined wise counsel with affectionate tenderness, so that the grief of his children may well be tempered by thankfulness that they are sons and daughters of such a parent; as a true follower of Christ he was a comforter to many in their hours of bereavement by his words of deep feeling and simple eloquence, while his sincere religious nature was shown in all church work—as a physician—though he did not take up that vocation until late in life, and against the advice of nearly all his friends—his sucess was marvelous. I do not speak of that poor sort of success which is measured by dollars and cents, but *real* success, manifested by saving lives, relieving suffering and distress, and making the world better and happier because of his having lived in it. How many families have had intense anxiety changed to comfort and reassurance by his efficient ministrations! And with what forebodings we now face the future! The martyr's crown grows dim and lusterless, the hero's wreath fades and withers, compared with such services as he rendered during his long years of practice. Perhaps the exposure during the stormiest night of last winter may have hastened his end, but there was no more thought of failure to respond to the call of duty than if he had been a patriotic soldier on a battlefield.

It is not for us weak mortals to understand why a life so full of usefulness in so many varied fields should be stricken down when hardly beyond its prime; we only know that "God's finger touched him and he slept."

ALAN FARQUHAR.

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MEDICAL ETHICS.

An Address Delivered Before the University of Maryland Medical Association

BY SAMUEL C. CHEW, M. D., LL. D.,

March 16, 1909.

The subject of Professional Ethics is not included in our curriculum for undergraduates, nor has it a place in the post-graduate course of which it might properly form a part; and yet it is worthy of attention as having an important bearing upon our professional duties.

Let us first consider what is meant by the term Ethics. The meaning of a word is often best ascertained by studying its etymological origin, and, although many words may have wandered by a sort of evolutionary process, as it were, from their first signification, yet the tracing of the gradual changes may be interesting and may show how the real and full meaning has been acquired, and sometimes how it has been lost.

The word Ethics is derived from the Greek ἔθος, or ἦθος, which are close of kin, and though not precisely alike they have a common origin, ἔθος meaning a custom, usage or habit and ἦθος meaning primarily an accustomed seat, whether an abode of men or a haunt or lair of beasts to which they resort, and thus later coming also to signify custom or habit, and from this, disposition and character as formed by habit. Both words are perhaps traceable to ἕζομαι, to sit, and thus related to the Latin sedeo, and probably through a remote common ancestry of the Indo-European stock to the English *sit*. Now, as habits of thought, temper or morality tend to form character, it can be seen how the subject of Ethics embraces the consideration of the things that tend to good.

But it may be said that though good habits tend to form good character, yet bad habits form bad character, and why, then, should the term *Ethics*, when used absolutely and without qualification, relate to the influences which form good character, ethical meaning what accords with propriety, while what does not so accord is unethical. Ethical conduct is proper conduct; unethical the reverse. In Bentham's phrase, "Ethics may be defined the art of directing men's actions to the production of the greatest quantity of happiness." He does not connect with it at all the idea of unhappiness or of any evil. When it is said that ethics is the science of morals, the same thought is suggested regarding the words "morals" and "morality," which originally and etymologically signified what was good or bad in manners and practices, but acquired and kept afterwards a good meaning when used absolutely, so that morality in a person implies rectitude of character and immorality the reverse.

And thus it would appear that words, like organisms, may tend to improve upon their original condition and acquire an invariably good meaning which they had not at first, and it may be shown that, like organisms, they may undergo a process of degeneration. Happily, the words "Ethics" and "Ethical" have attained and kept a good meaning and are restricted to such meaning when used in reference to conduct or character.

And here take that very interesting word *character* itself, which originally and etymologically has a neutral signification either good or bad, as modified by adjectives, and yet when used absolutely and by itself has generally a good sense, so that when we speak of a man of character we mean a man of good character. Trace for a moment the family history of this word character. It comes from the Greek, χαρακτήρ an instrument for marking, and that from χαράσσω, to sharpen, which itself, so philology tells us, is akin to our homely word *scratch*. It would seem a far cry from a scratch to a character, and yet the passage from the one to the other can be traced along the devious Indo-European path; a path which, though arid to some, may at times be found full of delightful surprises. For the instrument, the χαρακτήρ makes markings and thus impresses qualities or distinctive charac-

teristics, and the best of these survive when the word is used absolutely and form a good character, a thing that is marked with good. Now take some instances of degeneration in words, as showing how they may lose their good meaning and get a bad one. In early English and down to a comparatively recent time the word *temper* was used to indicate governance of disposition or restraint of excitability, so that one engaged in a quarrel or a controversy was said to display temper if in reply he governed his tongue or his passion. This proper use showed the origin of the word from the Latin *temperare,* to be moderate, to restrain one's self, and it is illustrated by a line from Pope:

"Teach me, like thee, in various nature wise,
To fall with dignity, with temper rise."

But now the very opposite meaning prevails, and one who gives way to angry passion is said to show a great deal of temper, the word having undergone a degeneration from its former good meaning.

Another instance of such degradation is found in the word "nervous," derived from the Latin *nervosus,* itself from *nervus,* which in classic Latin did not mean a nerve but a sinew, and stood for strength and vigor, and hence the English word meant "well-strung," "strong," "vigorous," and is illustrated by another line of Pope's:

"What nervous arms he boasts; how firm he treads."

But now the meaning is in common speech often reversed, though this is hardly sanctioned by good writers, and the word is used to indicate a condition of weak or irritable nerves. And yet I do not think that Dr. Johnson is altogether fair in referring to this use as belonging to what he calls "medical cant," for educated physicians do not employ the word *nervous* in this way either in writing or in speech. It is, of course, proper to speak of the "nervous system" and of "nervous centres," for that is a legitimate use of the word, indicating a system composed of nerves or centres composed of nerve cells. And yet the frequency with which the word "nervous" is used to connote a lack of nerve control shows a degradation from its proper use.

And now, going back to words which have acquired and retained a good meaning, we find that the terms "Ethics" and Ethical" relate to the practice of those customs or usages which are right and proper and thus belong to good character.

Now the subject of medical ethics, or the condition of things in our profession which is in accordance with proper courtesies and proper character, may be considered under two heads:

First—The ethics or proper courtesies to be observed towards our professional brethren and as regulating our relations with them; and

Secondly, the ethics or proper courtesies to be observed towards the community at large, and especially those who apply to us for professional counsel.

Under the first are to be considered the claims which physicians as such have upon each other. One of these is the claim, for so it may be called as being fixed by usage, for professional attendance without remuneration, which springs partly from the *esprit de corps,* the spirit which should govern physicians as belonging to the same brotherhood; and such attendance is customarily given also to those members of a physician's immediate family who are dependent upon him, but not further. There may be exceptions to this rule, as in the case of wealthy physicians, especially where the wealth is not the result of professional labors, but has come from outside sources. But even then it is most in accordance with the spirit of our calling that the demand should not be made nor the expectation shown, but that the subject should be left to the beneficiary's own sense of justice, when, if remuneration be tendered, it need not be refused. Again, if services, especially when they have been of an exacting character and have consumed much time, have been rendered to a physician who at his death should have left a large estate, it would be entirely proper to render an account against the estate; for the usage of professional courtesy is personal, terminating with death, and does not exist as to a family who are wealthy and who have no claim of courtesy against the attendant. The case is wholly different where a family are left with only narrow or moderate means; but that rests rather upon grounds of humanity than of courtesy.

In general the claim for service on the part of one physician upon another continues when the recipient is permanently incapacitated by age or sickness, but if the medical profession is abandoned for some other the claim, of course, ceases to exist.

Another ground upon which the usage of free professional services may rest is that of reciprocity, for what is gratuitously rendered should be gratuitously returned: "Freely ye have received, freely give."

Another ethical subject as between physicians relates to conduct in consultations. These are held in general for one or other of two reasons—the first when a young practitioner from inexperience really needs assistance; the other in specially important and grave cases to share and divide responsibility, or because of a natural desire on the part of the patient or his family for more opinions than one. In either case the consultant, if he find an error in diagnosis or treatment, should feel bound in ethics to protect his colleague's professional reputation and "to hide the fault he sees;" and this can always be done without violation of truth.

The consultant who suggests a change of treatment which he knows to be needless is chargeable with dishonesty, and with the desire of having it thought that he knows more than he really does. He is as one who

"Hints a doubt and hesitates dislike,
Willing to wound and yet afraid to strike."

Secondly, as regards the relations held to the general community, it may be said in passing that such matters as gratuitous professional services to ministers of religious bodies because of the work in which they are engaged, or to the poor on account of their poverty, are not properly ethical and do not belong to the subject of ethics, but rather to that of humanity, and every individual case must be considered upon its own merits. I would only refer in this connection to a saying of the wise and good Dr. Fothergill, that the poor were his best patients because the Lord was the paymaster.

An important question in our relations with the general public is that of the obligation to secrecy as to subjects of which we have knowledge only as physicians through professional confidence. I believe that the clergy are protected by law against compulsion to reveal things which they have learned through the confessional, and some moralists hold that they are justified in disavowing all knowledge thus obtained; that it is simply as though it were not known. A story is told of a priest to whom the crime of murder had been formally confessed, and when in a subsequent conversation his penitent began to speak of the case, "Stop!" said the priest; "do not say a word; this is not the confessional, and should I be called as a witness anything that you may now say I could be compelled to reveal." Now it may be held that the like protection should be given to a physician who as a physician has learned things which it would be to the injury or the discredit of his patient to have disclosed. I do not know whether any such case has been ruled upon.

RENAL CALCULUS.

An Address before the Doctors' Class at the University Hospital on January 29, 1909.

By Randolph Winslow, A. M., M. D.

CAUSES.

The causes of urinary calculus wherever it may be located are both constitutional and local. Stones in the kidney are generally dependent upon some constitutional dyscrasia, whilst those in the urinary bladder are frequently due to local conditions. Normally the the inorganic salts are held in solution in the urine, but when the urine becomes too highly concentrated or of too great acidity crystals are formed, which may lodge in some portion of the urinary tract and by accretion become calculi. The constitutional conditions that most frequently are productive of stone are gout, rheumatism, impaired digestion, improper food and unhygienic modes of life, whilst the local causative factors are foreign bodies, obstructive lesions of the lower urinary channels, such as stricture of the urethra and hypertrophy of the prostrate gland, with infection of the bladder Renal calculus naturally depends upon a constitutional rather than a local cause in the vast majority of cases, but in a few instances foreign bodies have become lodged in the kidney and have been the nuclei of stones; thus, a case is recorded in Dennis' System of Surgery, where a needle, which had been swallowed many years previously, had found its way into the kidney and had become encrusted with salt. It would be quite possible that bullets, spicules of bone or other foreign bodies might in some instances become lodged in the kidney and form calculi.

VARIETIES.

There are three great varieties of calculi—the uric acid and water, the oxalate of lime and the phosphatic—but they seldom consist of one salt and are usually mixed in composition. Rarer forms of calculi are the calsium carbonate, cystin, Xanthin and indigo. Renal calculi are generally of the uric acid or oxalate of lime varieties, but when infection of the pelvis occurs phosphatic stones are liable to form or to encrust stones of other varieties, if they have already formed.

COMPOSITION OF CALCULI.

Nearly all calculi consist of a nucleus and concentric rings of crystaline deposition. The nucleus may be of a different composition from the bulk of the stone: thus, it may be of uric acid, whilst the rest of the concoction is calsium oxalate or prosphates. Foreign bodies wherever lodged in the urinary passages will always become surrounded with salts and will be the nuclei of stones. Crystalization also occurs around clumps of bacteria, blood clot, mucus and sometimes animal parasites, hence at times the stone is hollow and without any apparent nucleus. I here exhibit a small stone removed from the kidney by me, which appears to be hollow and without a nucleus. Uric acid and oxalate of lime calculi form in acid urine, whilst those of the phosphates are found in an alkaline urine.

Uric acid calculi are densely hard, smooth or slightly rough and yellowish or brownish in color; oxalate of calcium stones are known by their very rough or tuberculated appearance, hence are called "mulberry" calculi from their supposed resemblance to a mulberry. They are also very hard, Phosphatic calculi are generally soft, friable and white and are found associated with an alkaline urine.

The calculi may be located either in the kidney, ureter or bladder, but the majority of them have been formed primarily in the kidney and have passed downwards and lodged in the ureter or bladder. Renal calculi vary in shape, size and consistence and may be single or multiple. They may be smooth or rough; frequently they are branched like coral, and often assume the shape of the renal pelvis, with branches projecting into the infundibule calyces. I here exhibit a large stone shaped like the pelvis of the kidney, with those smaller concretions that I removed from a woman some years ago. Kidney stones are usually small or of moderate size, but sometimes they assume large proportions, and instances are recorded where they have weighed as much as 19 ounces. As these calculi usually are of the uric acid or calsium oxalate variety, they are hard and rough and do damage to the renal structure. When infection has occurred and a phosphatic deposition has taken place, the stone may be soft and friable. The stone may be single, or there may be a great number of them; often one will be found in each calyx.

I wish at this point to revert to the anatomy of the kidney, which is incorrectly described in many text-books. In most cases the calyces do not empty into the pelvis of the kidney directly, but into upper and lower infundibula, or long, narrow channels which unite to form the pelvis outside the sinus of the kidney, hence there may be calculi in each calyx or infundibulum, possibly not in the pelvis at all. When the pelvis becomes distended it may form a large cavity within the kidney and may be the seat of a large stone or stones. One or both kidneys may be the seat of calculus, and if one is involved the other kidney is also very liable to become involved. It is probable that the disease is bilateral in from 12 to 15 per cent. of all cases.

GEOGRAPHICAL DISTRIBUTION.

Whilst urinary calculus is sufficiently common in most parts of the world, it is much more frequent in some countries than in others. It is of especial frequency in India, China and Egypt, and surgeons practicing in those regions acquire enormous experience in the treatment of this disorder. It is more common in some portions of a country than in other parts of the same country, and different races living in the same region differ in their susceptibility to the disease. In this part of the United States it occurs not rarely, but not

so frequently as in some other parts, and it is less frequent in the negro than in the white race. Why it forms at all, and why it occurs more frequently in one locality than in another, is a matter of surmise, but not of demonstration.

PATHOLOGY.

A calculus in the kidney is bound to set up more or less nephritis, if the stone is fixed and does not change its position then irritation and inflammation will be less than if it is movable. If the kidney remains aseptic, there may be but little pathological damage to the organ, but when infection occurs, as it usually does, either from the blood stream or by retrogression from the bladder, pyelo-nephritis and pyo-nephrosis are the natural consequences, and destruction of the organ and loss of life are by no means uncommon sequences.

SYMPTOMS.

In the absence of infection a calculus may remain latent, and give rise to no symptoms, or to but slight and vague uneasiness. Generally, however, irritation and inflammation of the kidney will take place to a sufficient degree to call attention to the fact that some pathological process is in operation and to suggest the suspicion that it may be the result of nephro-lithiasis.

The kidney is only palpable, unless it has become distended and displaced from pyonephrosis, hence we but seldom can feel this organ. In some cases of very large calculus, the kidney may be felt.

Pain is the symptom which is most constant and which first attracts the attention of the patient to his disorder. This pain is a variable symptom, since it may be slight if the stone is fixed, whilst it may be very noticeable if the concretion is movable and readily changes its position in the pelvis of the kidney. The pain may radiate downward along the course of the ureter, when small particles gain entrance into this tube and cause nephritic colic, but generally the pain is an ache in the kidney itself, which may be intensified by pressure on this organ as well as by exercise or any jolting. Blood in the urine can usually be found in cases of renal calculus, either in sufficient quantity to cause a distinct coloration of the urine, or by a microscopic examination. The hemorrhage is seldom marked, as it sometimes is in tuberculosis and malignant conditions of the kidney. Pyuria is absent in those cases in which infection has not occurred, whilst it is very evident when pyelo-nephritis and pyo-nephrosis have developed. In all cases there will be some increase in the white blood cells as seen under the microscope. Vesical irritability is a frequent sign of renal calculus, and often the bladder symptoms predominate over those referable to the kidney. Increased frequency of micturition with pain may be the most evident symptoms. If the urine is acid, and contains blood or pus, even though the symptoms are such as to call attention to the bladder, it is probable that the trouble is located in the upper, rather than in the lower, urinary tract. Anuria may in rare cases occur, either from a blocking of both ureters by calculii, or by reflex action. I have a small concretion which caused reflex anuria, and gave one much anxiety until it passed, when the urinary flow was promptly re-established. The passage of concretions will of course serve to direct attention to the kidney, but these are not often present in the urine. Digestive disturbances are often associated with nephro-lithiasis, such as nausea, vomiting and impaired digestion.

The symptoms already mentioned are not sufficiently characteristic to warrant a positive diagnosis of calculus, as they may be caused by very diverse conditions, but they are highly suggestive. We have, however, at our command other methods of investigation, from which very positive information may at times be derived. The most important and valuable means of diagnosis possessed by us at this time is the radiograph, which when showing a positive shadow is diagnostic in the highest degree, but the absence of a shadow does not indicate certainly that a stone is not present; neither does the presence of a shadow indicate unerringly that a stone is present.

When symptoms of irritation of the bladder do occur, especially when associated with acid urine, a cystoscopic examination should be made, and if the bladder walls appear to be healthy, with perhaps a redness and pouting of one or both ureteral orifices, the trouble is higher up in the urinary tract. Catherization of the ureters will also give valuable aid in determining the nature and location of the trouble. At times

the introduction of a wax-tipped ureteral bougie will indicate the presence of a stone in the pelvis of the kidney or ureter, by means of the scratches that may be found on the polished surface of the bougie.

From what has been said it is evident that the symptoms of nephritic calculus are, in most instances, not diagnostic, and it is only by a careful examination of their phenomena that an approximately correct interpretation of their meaning may be obtained.

TREATMENT.

When a calculus has formed in the kidney, there is no known means for its removal, except by a surgical operation. The administration of drugs may at times alleviate the symptoms, but the stone remains. It is necessary therefore to expose the kidney, incise its cortex, and remove the concretion, or in some cases it may be more convenient to open the pelvis of the kidney and extract the stone through this incision. Ordinarily it is better to make the incision through the vascular kidney, as healing is more certain and rapid than when the pelvis is incised. As a rule, it is better and safer to employ the lumbar route, though sometimes it will be necessary to reach the kidney by a transperitoneal operation. Usually the incision is placed in the loin, either in an oblique or perpendicular direction, the muscles are divided or a separation of their fibres made by blunt dissection, the posterior lamella of aponeurosis divided and the perinephric fat exposed and pushed aside, when the kidney is exposed to view. This is separated from its connections and forced into the wound or it may be brought out upon the back of the patient. The renal vessels are grasped with the fingers or a padded forceps, to prevent hemorrhage, and an opening made through the kidney substance and the stone or stones grasped in forceps and removed. Sometimes it may be necessary to crush the stone, before it can be removed from its bed. Any small fragments may be removed by irrigation. If the kidney is infected, drainage by means of tube and gauze must be employed; if it is not infected sutures of catgut are passed entirely through the organ and the wound in the kidney closed. The external incision is sutured except for a space large enough to permit the placing of a small drain down to the kidney. Rapid healing generally ensues, with relief of the distressing symptoms.

REPORT OF A CASE OF UNDESCENDED TESTICLE OF THE PERINEAL VARIETY.

By J. Ernest Dowdy, '09,

Senior Medical Student.

Before reporting this case, we may refresh our memory regarding the steps in the descent of a normal testicle.

The testicles are developed from the genital ridge of the Wolffian body. The Wolffian duct becoming the vas. The testes in early intrauterine life lie extra-peritoneal and just below and in front of the kidneys.

In their normal descent they pass into the inguinal canal during the seventh month of gestation and into the scrotum during the eighth month.

They may be arrested at any point in their descent or may take an aberrant direction and be found lodged under the skin of the abdominal wall, the thigh or perineum. One or both testicles may fail to follow the normal course and may be retained, in the abdomen, or in the inguinal canal. The causes which operate to prevent this normal descent of the testicles are obscure. It may be accounted for, however, by assuming that the external ring is of too small a size to allow the testicle to pass through it, or that the vessels accompanying the spermatic cord are too short to allow the cord itself to be stretched sufficiently to allow the testes to reach the bottom of the scrotum.

The wearing of a truss on account of a hernia in cases where the descent of the testicle has been delayed after birth may also prevent the testes from arriving at its normal place in the scrotum.

The causes of cruro femoral and perineal ectopy are still more obscure. It is thought, however, that an over development of certain bands of the gubernaculum will have the effect of drawing the testes to one side and thus occasion the aberrant course. The result of ectopy is impairment of the growth and development of the testis, so that it remains undersized, but probably possesses the power of forming spermatozoa, unless the structure is destroyed by attacks of inflammation, which are very liable to occur. After the testicle has been disorganized sterility of course follows.

Bilateral retention does not interfere with development, for the subjects of this misfortune have all the characteristic appearance of the male sex, and in no way differ from their brothers (except they are not capable of procreating their species).

In unilateral retention there is little to be anxious about, for one perfect testicle will suffice for the development and procreation of their species.

Complicating maldescended testes very often is hernia, and especially is this true if the testicle lies in the inguinal canal, as it may interfere with the wearing of a truss, so that strangulation of the hernia is very liable to occur. The testicle when not lying protected by the thighs, in the scrotum, is very liable to be struck and bruised, and the ectopic testicle rarely escapes several attacks of traumatic inflammation. It may also be the subject of gonorrheal inflammation from extension of a gonorrhea from the posterior urethra.

Malignant disease is very apt to occur in ectopic testicles, and is predisposed by attacks of inflammation to which the testicles in this situation are so liable when the malignant disease does involve this form of undiscovered testicle it almost invariably proves fatal, death taking place in usually the short space of one year. The sarcomatous variety of tumors is the most common. The perineal variety of maldescended testicle was first described by Hunter in 1786 and afterwards by Curling in 1841, the subject has received very little attention by surgical writers however. Curling was the first to give a detailed description of the condition in 1857, and a report of nine collected cases. He was also the first to treat the condition by operation. The patient was an infant four weeks old, and the results of operation was unfortunate. Goodard, in 1857 and 1860, reported two interesting cases, one in a man 56 years of age and another 22. The first case was originally an inguinal ectopia, which after the wearing of a bandage for a considerable time, became perineal, the second was cruroscrotal ectopia.

Amiandale, in 1879, was the first to report a case successfully treated by surgical interference.

Monods Sevillon, in 1889, collected 30 cases of perineal ectopia, which number Weinberger, in 1899, increased to 65.

Adding to this the more recent collection by Klein there are 81 cases up to date.

As to the frequency of perineal ectopia Remies and Marshall report only 17 cases in 14,400 recruits examined for miliary service, but not one of these is stated to be perineal.

Godard, in 53 cases of ectopia, found only three examples of perineal variety.

McAdam Eccles, in his work on imperfectly descended testes, states that out of 936 instances of imperfect descent of the testes, associated with hernia, only five were found to be perineal in variety. At the Hospital for Ruptured and Crippled Children in New York there have been observed during the past 18 years 737 cases of undescended testes, and of these only 15 were of the perineal variety.

As regards the age of the patient while the disease is of congenital origin, the testes are not always found in the perineum at birth. In certain cases it is situated just outside of the inguinal ring, or has passed below the pubic bone and later on reaches the perineum. In a great majority of cases the condition is unilateral.

Cases have been reported of the condition being found in both father and son.

The case coming into the Genito Urinary Department of the University Dispensary gave the following history: A young white man 17 years old, well developed and healthy in appearance, but complaining of a dull pain in his testicles, which had been present for past four or five days, and he attributed it to an injury received while carrying a tray in a baker shop. On examination the left testicle was found normally descended into the scrotum. The right testicle could be distinctly felt in the perineum, located about an inch anterior to the margin of the anus, and half inch to the right of the median raphe. It was freely movable, and was about the size of a walnut. The condition had been present since birth and had caused him no inconvenience until receiving the injury a few days before.

No other members of his family are suffering with the same condition. His father has had an oblique inguinal hernia since childhood. An operation was advised, but the patient refused.

ANNUAL REPORT OF DEMONSTRATOR OF ANATOMY, UNIVERSITY OF MARYLAND.

By J. W. Holland, M. D., *Demonstrator.*

Faculty of Physic, University of Maryland:

I have the honor to submit the following report of the laboratory of practical anatomy for the session of 1908-1909.

STUDENTS ENGAGED IN LABORATORY.

Medical—	
Second year	48
First year	57
Advanced, Medical	2
Post Graduates, Medical	8
Second year Medical (Extra Work)	5
Total number of Medical Students	120
Dental—First and Second year	49
Advanced Dental	1
Total number of Dental Students	50
Total Medical and Dental	170

FAILED TO ACCOMPLISH REQUIRED WORK.

Medical—	
Second year	1
First year	8
Dental	7
Total failures	16

MATERIAL.

Received during 1908-1909	48
From Storage—	
Whole subjects	48
Cut subjects	12
Received Fresh—Whole subjects	2
Left from Session of 1907-1908	11
Total	73
Distributed during 1908-1909—	
To Medical Students	29
To Dental Students	12
For demonstrations in Practical Surgery	6
To Professor of Anatomy	2
To Post Graduate Students	6
Unfit for use	7
Left from 1908-1909	11
Total	73

As a result of the efforts of the Anatomy Board to curtail the number and extent of autopsies upon subjects destined to become the property of the Board, the material on the whole was somewhat better than in previous years. There has been fewer autopsies and less mutilation by post-mortem operations than usual.

It was decided by the Board at its last annual meeting, in November, 1908, to destroy all subjects which had been extensively mutilated by post-mortem operations, thus avoiding the expense of embalming and storing such material. It was also decided to allow deduction of the price of all subjects, among those allotted to the various medical colleges to be used in 1908-1909, which proved to be very extensively mutilated by post-mortem examination.

The supply of material distributed from the storage plant by the Anatomy Board during the session of 1908-1909 was ample for all purposes. Only two fresh subjects were delivered directly to the laboratory and these were obtained for special use.

The work of the second year medical class was very satisfactory and gratifying, there being but one failure.

Owing to the limited capacity of the laboratory as well as the small number of demonstrators it is necessary that the dental class completes its work before the first year medical class can begin work. During the last session it was found impossible to have the first year medical class begin work before February 15th, and though the class continued dissecting till the close of lectures, there was not enough time to accomplish as much as should be expected of this class.

One result of this abridgement of first year work is to crowd the second year laboratory work. The whole session is now required in the second year to complete the course.

It is gratifying to note that eight post graduate students were engaged in practical anatomy during the session. Five second year students demonstrated commendable zeal by devoting their entire Christmas vacation to extra laboratory work. Nineteen complete sets and many odd bones were prepared during the session. These have been added to the museum, where needed, and the balance stored for use of students during the next session.

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CHANGES IN THE FACULTY OF PHYSIC.

In consequence of the resignation of Prof. S. C. Chew from the Faculty of Physic it has become necessary for the Faculty to make the following changes in its body:

Prof. C. W. Mitchell has been elected to the chair of Professor of Medicine and Diseases of Children, thus consolidating the two chairs.

Prof. Mitchell graduated in the class of 1881 and has been closely associated with the educational work of the University since his graduation. In 1896 he entered the Faculty and Board of Regents as Prof. of Therapeutics, Diseases of Children and Clinical Medicine. He served as Dean of the Faculty for several years. Prof. Mitchell has been regarded by his colleagues and by the student body as an able, industrious and popular teacher. His loyalty and devotion to the University of Maryland have been tested on many occasions and never found wanting. As a teacher he has made good on all occasions. In character, scholarship and attainments he is a worthy successor of Nathaniel Potter, Elisha Bartlett, Wm. Powers, Samuel Chew, Richard McSherry and Samuel C. Chew, the distinguished men who have filled the chair of medicine from the organization of the University to the present time.

Prof. Arthur M. Shipley has been elected a member of the Board of Regents as Professor of Therapeutics and Surgical Pathology.

Prof. Shipley graduated in the class of 1902 with the highest honors of his class. For some four years he was Medical Superintendent of University Hospital, where his work was marked for its thoroughness and ability.

Among the younger graduates of the University Prof. Shipley stands out as a man of distinguished promise and of rapid advancement. He combines all the elements of the teacher, clinician and scientific worker.

Prof. Harry Adler, of the class of 1895, has been elected Professor of Clinical Medicine and Director of the Clinical Laboratory. After graduation Prof. Adler spent several years in post-graduate study in Europe. Since his return he has been associated with the educational work of the University, in which he has shown splendid qualifications as a teacher and scientific worker.

As President of the Hebrew Hospital he has made a high distinction as an organizer and administrator, having brought this institution into the front rank of our city hospitals. Prof. Adler has a wide field for the development of his talents in the clinical work of the University.

Prof. I. J. Spear, class of 1900, has been made Clinical Professor of Nervous and Mental Diseases. After two years of work in Europe Prof. Spear took up this line of work at the University. He has made such progress as a teacher that his advancement was easily won. Prof. Spear has a distinguished career ahead of him.

OUR MEDICAL LIBRARY.

At the present writing there are more than nine thousand bound volumes upon the shelves due principally to the endeavors of Dr. Eugene F. Cordell, who, when he assumed control some five or more years back, found a nucleus of about four thousand volumes uncatalogued and uncared for. By the assiduity and attention of the librarian more than five thousand volumes have been added to the collection, so that now this library is the second medical library in size in Baltimore, and contains many rare old volumes bequeathed by the worthies of the years gone by. More than sixty current medical journals are upon the tables of the library, which is open to our students, alumni and members of the faculties. It is housed in Davidge Hall in a large, well-lighted room. Anybody who wishes to do something for the University can materially assist by either giving or bequeathing their library to the University. He may rest assured that any books donated will be well cared for, protected, and accomplish a great amount of good. Here is an opportunity to do something for the University, occasionally donate a modern book or two; place in the hands of the students the best literature of the day, and you may well feel assured that you have done something for your fellow man.

MEDICAL ETHICS.

In the present issue of The Bulletin will be found a scholarly paper on "Medical Ethics," by Prof. S. C. Chew.

The Bulletin knows of no one who can write upon this subject with more authority than Professor Chew. During a long and active professional life he has observed the highest standard of professional conduct in all of his relations toward his profession and towards the public, and has exercised an influence for the uplift of professional education and practice which few men have enjoyed. Professor Chew has always stood for the highest ideals and aims of professional work and now at the close of an active and most honorable professional career it is most fitting that he should give to his professional brethren his views on medical ethics. In treating this subject he has presented the fundamental principles which should govern the practitioner in his relations towards his profession and towards the public. He has said in terse language all that can be said upon this subject, leaving the details of professional conduct to the good sense, to the morals and to the conscience of each individual practitioner.

In closing with the inspired words—"All things whatsoever ye would that men should do to you, do ye even so to them," he has expressed the highest type of human conduct ever given to man.

Long before the dawn of Christianity Buddha, in the East, preached the substance of these teachings to his followers, but it remained for the lowly Nazarene to give them a force and moral influence which have kindled in the hearts of men a love and respect for the grandest of all ethical principles.

In ancient Greece, the Stoics, Academics, Parapatetics and Epicureans gave to their followers systems of philosophy which sought to establish the highest principles of conduct and to confer the greatest degree of happiness upon mankind.

Pythagoras, Socrates, Plato and Aristotle gave an impulse and moral force to the teachings of their respective sects, which have had wide and commanding influence over the intellectual and philosophical culture of succeeding generations. Their principles of ethics seem to lack only one essential idea. The principles of human love and brotherhood were smothered under the cloak of a moral and intellectual culture which made happiness the aim of conduct and duty an open question for discovery. Cicero, in his Treatise, De Officiis, addressed to his son Marcus, sums up the moral duties of mankind in a discourse of remarkable intelligence and philosophical grandeur. His ethical teachings, largely borrowed from the writings of Panaetius, are so wise and clever that modern philosophy has scarcely improved them.

To quote his language, we have the true ethical spirit which runs through all his writings, "For while many subjects in philosophy, of great insight and utility, have been accurately and copiously discussed by philosophers, the most extensive seems to be what they have delivered and enjoined concerning the duties of mankind; for there can be no state of life, amid public or private affairs, abroad or at home—whether you transact anything with yourself or contract anything with others—that is without its obligations. In the due discharge of that consists all the dignity, and in its neglect, all the disgrace of life."

Where can one find rules of conduct in closer harmony with the golden rule than is here stated?

Of the more modern teachers of philosophy, Dr. Samuel Johnson, in *Rambler,* gives expression to the following thoughts which are so nearly related to the highest ethical teachings that they should be considered by all who aim at excellence in life's great work.

"It must be strongly impressed upon our minds that virtue is not to be presumed as one of the means to fame, but fame to be accepted as the only recompense which moralists can bestow on virtue—to be accepted with complacency, but not sought with eagerness. The true satisfaction which is to be drawn from the consciousness that we shall share the attention of future times, must arise from the hope that with our name our virtues will be propagated and that those whom we can not benefit in our lives may receive instruction from our examples and incitement from our renown."

The Bulletin voices, it believes, the wishes of its readers when it expresses the hope that Professor Chew, in the evening of a well-spent life, in the enjoyment of a quiet home, in his library filled with the world's best literature, will find ample time and inclination to prepare a series of articles upon ethical and literary subjects for the profession.

ITEMS.

The last meeting of the Dorchester County Medical Society held in Cambridge with Dr. E. Eakin Wolff, class of 1899, in the chair, was addressed by Dr. C. W. Mitchell. Dr. H. V. Harbaugh, class of 1907, was admitted to membership, and upon the motion of Dr. Guy Steele, Dr. C. W. Mitchell to honorary membership.

Dr. Salvatore Demareo has returned from East Orange, N. J., where he was called to operate upon a case of appendicitis.

Doctor and Mrs. Gordon Wilson have returned from their honeymoon and are guests at the Chattolanee.

Dr. D. C. Absher, class of 1909, who was operated upon at the University Hospital recently, is reported to be doing nicely and will soon be able to be about.

Dr. William F. Schwartz, class of 1908, formerly resident physician to the insane department of Bayview Asylum, has removed to 1200 North Caroline street.

Dr. R. C. Bay, medical superintendent of the University Hospital, has been commissioned a captain in the medical corps of the Maryland National Guard and assigned to the Fifth Infantry.

Dr. Eugene F. Cordell has returned to the city after a fortnight spent at Atlantic City, where he attended the meeting of the American Medical Association.

Dr. N. E. Berry Iglehart, class of 1889, of Baltimore, attended the sessions of the American Medical Association at Atlantic City.

Dr. William P. E. Wyse, class of 1886, and Mrs. Wyse have returned from a short visit to Annapolis.

Doctor and Mrs. Henry J. Berkeley are summering at Magnolia, Mass.

Dr. Frank J. Kirby, class of 1892, delivered the principal address to the graduates at the recent commencement of the St. Joseph's Hospital Training School for Nurses.

Dr. Ernest Neale has closed his city home and will summer at Ocean City, Md.

Miss Ruth Kuhn, has resigned the superintendency of the Atlantic Coast Line Hospital, Waycross, Ga.

Drs. Hiram Woods and Charles O'Donovan addressed a meeting at Centreville, June 9, 1909, held to create interest in the proposed hospital to be erected in or near Centreville.

Dr. Charles W. Mitchell, who has been the guest of President Woodrow Wilson at his home in Princeton, has returned to his home.

Dr. A. D. McConachie has been spending a fortnight at Atlantic City.

Drs. L. Gibbons Smart, R. C. Massenberg, J. C. Clarke, M. G. Porter, James F. H. Gorsuch and J. H. Bates, all of Baltimore county, attended the last meeting of the Baltimore County Medical Society held at Towson. Dr. J. Clement Clarke, superintendent of Springfield Asylum, at Sykesville, Md., invited the Society to hold their July meeting at his Hospital.

Miss Ann Elizabeth Chapman, a graduate of the University Hospital Training School for Nurses and for several years after graduation in charge of the operating rooms at the University Hospital, at present superintendent of the Emergency Hospital, Easton, Md., has been notified by the Federal authorities that she passed second in the competitive examinations for trained nurses for service in Panama, held throughout the country in the spring, and has been asked to inform them of the earliest date at which she can report in New York to be sent to the Ancon Hospital, on the Pacific Slope of the Panama Canal Zone. Miss Chapman graduated with the class of 1906. Miss Mary Hamlin, another of our graduates, has been successful in an examination for nurses for service in the naval branch of our military organization.

Our alumni hold the following positions at the College of Physicians and Surgeons, Baltimore:

Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery, and Dean of the Faculty—Dr. Charles F. Bevan.

Professor of Medical Jurisprudence and Director of the Pasteur Institute—Dr. N. G. Keirle.

Professor of Obstetrics and Gynecology—Dr. George W. Dobbin.

Professor of Pathology and Bacteriology—Dr. W. Royal Stokes.

Professor of Anatomy and Clinical Surgery—Dr. A. C. Harrison.

Professor of Clinical Medicine—Dr. Cary B. Gamble, Jr.

Dr. Eugene Lee Crutchfield, fellow and gold-medalist of the Society of Science, Letters and Art, of London, England, has been elected to a fellowship in the American Academy of Medicine. This is the most scholarly and exclusive medical organization in the United States.

Dr. Solomon L. Cherry, class of 1908, has been appointed Pathologist to the Hebrew Hospital, Baltimore; Drs. Samuel H. Long and Everette Iseman, assistant resident physicians.

Dr. J. S. Norman declined the appointment as assistant resident physician, Bayview Asylum, and Dr. E. B. Wright received the appointment.

Dr. Thomas E. Satterthwaite, LL. D., 1908, of New York, has been appointed by this University a delegate to the 350th anniversary of the Foundation of the University of Genoa.

Dr. E. W. Pressly, class of 1887, of Glover, S. C., has been in poor health for over two years. Recently he experienced a slight paralytic stroke.

Dr. Nathan Winslow, class of 1901, has been elected managing editor of the Maryland Medical Journal.

Dr. E. G. Ballenger, class of 1901, is editor of the Record and Journal of Medicine, published at Atlanta, Ga.

Miss Helen Wise, a graduate of the University Hospital Training School for Nurses, and superintendent of the Peninsula General Hospital at Salisbury, Md., has resigned to take charge of the Lelia Morton Memorial Station, at Leesburg, Va. The Memorial was established at Leesburg by ex-Vice-President Levi P. Morton in memory of his daughter, and since its inauguration five years ago has employed the services of a trained nurse for the benefit of the people of Leesburg and vicinity. Miss Wise is a daughter of Mr. William N. Wise, of Leesburg.

Dr. Jacob Wheeler Bird, class of 1907, of West River, Md., for the past three years connected with the University Hospital, first as resident student, then as assistant resident surgeon and during the past year with the additional office of assistant superintendent, has located at Sandy Spring, Md., taking the place of the late Dr. Roger Brooke, also a graduate of this school.

Dr. Frank O. Rogers, class of 1901, spent Friday, June 2, 1909, in Baltimore. He is the same old Frank, as full of fun as ever. He informs THE BULLETIN that Dr. Edward C. McEachern, class of 1901, died recently of tuberculosis; also, of the death of Dr. William H. Whitehead, of Rocky Mount, N. C., class of 1870, father of Dr. Joe Whitehead, class of 1899, also of the same place. Amongst some of the other news gleaned from him were that Dr. Louis Haines, class of 1902, of Winston-Salem, N. C., has given up medicine and taken to the brick manufacturing business; that Dr. R. T. S. Steele, class of 1899, of North Carolina, has forsaken medicine and removed to Pennsylvania, where he has entered the mining business.

Dr. Murray Hollyday, class of 1908, formerly resident physician in Church Home and Infirmary, has been appointed resident physician to the Maryland Steele Company, Sparrows Point, Md.

Dr. Gideon N. Van Poole, class of 1899, captain United States Army Medical Corps, has been relieved from duty at Fort Slocum, N. Y., and will proceed at the expiration of his present leave of absence to Fort Sheridan, Ill., for duty.

Dr. W. E. Wiegand attended the meeting of the American Medical Association at Atlantic City.

Dr. William T. Councilman, class of 1878, Professor of Pathology in the Harvard Medical School, has been elected a trustee of the American Medical Association.

Dr. George Wythe Cook, class of 1869, of the District of Columbia, has been appointed by the President of the American Medical Association a member of the Committee on Rules and Order of Business, and Dr. George Lane Taneyhill, a member of the Reference Committee on Legislation and Political Action.

At the meeting of the American Medical Association Dr. Fry, of Washington, defended ventro-suspension, though fixation occasionally occurred by accident. He objected to the Alexander operation owing to the difficulty of isolating the ligaments. He thought the Baldy-Webster operation the best yet described as it so completely lifted the prolapsed ovary.

Dr. Branch Craig, class of 1909, had the honor of attending the highest grade before the recent examination of the North Carolina State Medical Examining Board. The Bulletin takes this opportunity of congratulating and thanking Dr. Craig for the credit he has reflected upon his Alma Mater.

We are also glad to report that every candidate from the University of Maryland appearing before this Board did us the credit of passing.

A diploma of honor for an exhibit of superior merit was awarded to the University of Maryland at the Atlantic City Meeting of the American Medical Association.

Professor Hiram Woods attended the recent meeting of the American Medical Association held at Atlantic City.

Professor R. Tunstall Taylor is spending a few days in Boston.

Dr. William Royal Stokes delivered an address to the recent graduates of the College of Physicians and Surgeons, Baltimore, at their banquet at the Hotel Belvedere.

The Maryland Committee for the Prevention of Blindness has been organized with our alumni occupying the following offices:

Vice-Chairman—Dr. Hiram Woods.

Medical Committee—Louis Allen, J. Whitridge Williams, Hiram Woods, Samuel Theobald, Frank Crouch, Herbert Harlan, Guy Steele, L. B. Henkel, Jr., W. F. Hall, Robert L. Randolph, R. Lee Hall, H. O. Reik, J. L. Lewis, James J. Carroll, O. M. Linthicum, Marshall Price, G. I. Barwick, H. W. McComas, F. O. Miller, J. G. Selby and R. S. Page.

Dr. William N. Bisphan, class of 1897, now a major in the United States Army, has been ordered from San Francisco to Fort Leavenworth, Kan., for duty at the United States Military Prison.

At the annual meeting of the Faculty of the Maryland Medical College our alumni were elected to the following offices:

President—Dr. A. D. McConachie.

Vice-President—Dr. J. W. Funck.

Dean—Dr. Harry Gross.

Assistant Dean—Dr. W. S. Smith.

On invitation of the Nebraska Pharmaceutical Association, Dr. Henry P. Hynson, professor of the practice of pharmacy in the department of pharmacy of the University of Maryland, made an address before the Western organization at their annual meeting beginning June 15.

Dr. W. J. Riddick, acting assistant surgeon, United States Navy, has been ordered to duty at the Charleston Navy Yard, Charleston, S. C.

Dr. H. E. Jenkins, acting assistant surgeon, has been ordered to duty at the Naval Hospital, Norfolk, Va.

Dr. Charles H. O'Donovan is summering at his country place, Wicklow, near Catonsville.

Miss Nettie Flannagan, former superintendent of nurses, has accepted the superintendency of nurses, St. Luke's Hospital, Spokane, Washington. She entered upon her duties June 1, 1909.

Miss Augusta Russell, a graduate of the University Hospital Training School for Nurses, has resigned her position as superintendent of nurses, Maryland State Sanatorium for Tuberculosis, Sabillasville.

Dr. Thomas J. O'Donnell, class of 1903, a well-known young physician of South Baltimore, has been made a police surgeon by the Board of Police Commissioners. He succeeds Dr. Rastus Ransom Norris, class of 1904, police physician for the First Medical District. Dr. O'Donnell is one of the most prominent of the young physicians of South Baltimore and is widely known in that section. He is a graduate of the medical department of the University of Maryland, and was at one time resident physician in St. Joseph's Hospital.

Dr. Norris has removed to Crisfield, where he will engage in the practice of his profession.

Dr. Gordon T. Simonson, class of 1896, is located at Crisfield, Md., where he enjoys a large and lucrative practice.

Dr. Joseph W. Holland, class of 1896, has been advanced to the position of Associate Professor of Anatomy.

Dr. Clarence E. Collins, class of 1902, is located at Crisfield.

Dr. W. H. Coulbourn, class of 1901, is located at Crisfield.

Dr. William D. Cawley, class of 1902, is located at Elkton, Md.

Dr. Albert Scott Harden, class of 1901, is located at Newark, N. J.

Dr. Robert Lee Hall, class of 1901, is located at Pocomoke City, Md.

Dr. Frederick William Schlutz, class of 1902, of Minneapolis, has sailed for Europe, where he will study in the clinics of Germany and Vienna.

Dr. A. W. Dissosway, class of 1905, of Plymouth, N. C., recently, while in the city, paid the hospital a hurried visit. He reports that he is doing nicely.

Dr. Ernest Rowe, class of 1906, has located in Baltimore, and will devote his entire attention to diseases of the nose, throat, eye and ear. During the past year he was superintendent of the Baltimore Eye, Ear and Throat Hospital.

Dr. John R. Winslow has resigned from the staff of the Presbyterian Eye, Ear and Throat Hospital and has accepted a position upon the staff of the Baltimore Eye, Ear and Throat Hospital.

Amongst the many, many eulogistic expressions anent the resignation of Professor Samuel C. Chew from the chair of medicine was the editorial in the Baltimore *Sun* of recent date, which is herewith appended:

Long and Honorable Career.—The resignation of Dr. Samuel C. Chew from the chair of the Practice of Medicine in the faculty of the University of Maryland severs an association which has continued personally and by heredity for the greater part of the life of that venerable institution. In 1907 the University celebrated its centennial. More than eighty years before that celebration, when the school of medicine was less than twenty years old, Dr. Chew's father, the elder Dr. Samuel Chew, who came up from Calvert county, entered as a student of medicine. Fourteen years later he was appointed to the chair of Materia Medica, and afterward succeeded to that of the Practice of Medicine, which he occupied up to the time of his death in 1864. His son, the present Dr. S. C. Chew, then went into the faculty—first as professor of Materia Medica, and then to the chair of the Practice of Medicine, which he has just resigned. He has, therefore, been a member of the faculty for nearly 45 years.

In 1907 the University conferred upon him the degree of doctor of laws, and in presenting him on that occasion Mr. John P. Poe said of him: "During a professorship of 43 years thousands of students have had the benefit of his luminous and comprehensive instruction, and now, with a mind of great original force, enriched by the valuable stores of a wide and diversified experience and strengthened by assiduous cultivation and ripe scholarship, he still invigorates the University by the fruits of his high character, matured wisdom and unusual attainments."

Dr. Chew succeeded Mr. S. Teackle Wallis as president of the trustees of the Peabody Institute

and still occupies that important place. Few citizens of Baltimore are better known to the people of the city in which he has spent his honorable and useful life, or are more generally honored and beloved than Dr. Chew.

Dr. Irving J. Spear has been elected clinical professor of Diseases of the Nervous System and Pschiatry.

President Thomas Fell has been notified by the Army authorities that St. John's College, Department of Arts and Sciences, has been designated as one of the distinguished military institutions of the country, as a consequence of which he may designate one of his graduates for appointment as second lieutenant to the United States Army. No mental requirements are necessary for the appointee as a perquisite to his commission, but he must pass the ordinary physical examination.

Dr. John C. Travers, class of 1895, who left America six weeks ago to accept a government position in the Philippines, writes concerning his impressions of Hawaii, where he stopped en route to Yokohama, Japan, that he was charmed with the equable climate and productive soil of Hawaii, as well as the hospitality of the residents of Honolulu. Of the climate he says: "The combination of tropical sunshine and sea breeze produces a climate which can be compared to nothing on any mainland or to any other island group. Hawaii has a temperature which varies not more than ten degrees through the day, and which changes the year around from 55 to 90 degrees. Sweltering heat or biting cold are unknown, sunstroke is a mythical name or an unthought of thing. A frost bite is heard of no more than a polar bear. Conjure up the memory of the most perfect May day, the kind you are probably having at home at the present time. A day when sunshine, soft airs and the fragrance of buds and smiling Nature combine to make the heart glad. Multiply it by 365 and the result is the climate of Hawaii." He goes on to say that the fruit packers of Hawaii have made fortunes, and there is a bright future for those who engage in the industry. Sugar is the staple product, the treaty of reciprocity admitting sugar free to American markets having resulted in so fostering the industry that $100,000,000 is now invested in it, and still there is waste land awaiting cultivation. Doctor Travers practiced for many years in South Baltimore.

The University of Maryland Alumni of the American Medical Association held their annual meeting at the Wiltshire, Atlantic City, on Tuesday, June 8, 1909. In the absence of the president, Dr. Laurence D. Gorgas, of Chicago, Dr. G. Lane Taneyhill, of Baltimore, vice-president, presided. Dr. Arthur Ewens, of Atlantic City, welcomed the visitors. The following officers were elected:

President—Dr. G. Lane Taneyhill.

Vice-President—Dr. A. A. Matthews.

Secretary—Dr. G. B. M. Bowen, Vernol, Utah.

Fifty-two sat down to the banquet. Dr. A. D. McConachie was toastmaster. Speeches were made by Drs. Randolph Winslow, J. S. Hartman, J. S. Stone, etc. Those present were:

Doctors—

Harry Adler, 1895, Baltimore.
Charles Bayley, Jr., 1904, Baltimore.
Josiah S. Bowen, 1903, Mt. Washington, Md.
G. B. M. Bowen, 1887, Vernol, Utah.
Frank E. Brown, 1893, Baltimore.
T. Harris Cannon, 1901, Baltimore.
Albert H. Carroll, 1907, Baltimore.
James J. Carroll, 1893, Baltimore.
Lee Cohen, 1895, Baltimore.
E. V. Copeland, 1905, Round Hill, Va.
Eugene F. Cordell, 1868, Baltimore.
G. Wythe Cook, 1869, Washington, D. C.
James M. Craighill, 1882, Baltimore.
Andrew J. Crowell, 1893, Charlotte, N. C.
S. Thomas Day, 1889, Port Norris, N. J.
Curran B. Earle, 1896, Greenville, N. C.
Arthur E. Ewens, 1904, Atlantic City, N. J.
Frank V. Fowlkis, 1887, Burkeville, Va.
Henry M. Fitzhugh, 1897, Westminster, Md.
Monte Griffith, 1896, Washington, D. C.
Jos. E. Gichner, 1890, Baltimore.
Norton Royce Hotchkiss, 1891, New Haven, Ct.
Jacob H. Hartman, 1869, Baltimore.
Albert S. Harden, 1901, Newark, N. J.
Jos. L. Hirsh, 1895, Baltimore.
Richard Hall Johnston, 1894, Baltimore.
Frank J. Kirby, 1892, Baltimore.
Dorsey W. Lewis, 1896, Middletown, Del.
Edgar B. LeFevre, 1905, Inwood, W. Va.
Robert L. Mitchell, 1905, Baltimore.
Chas. W. McElfresh, 1889, Baltimore.
Robert A. Moore, 1891, Durham, N. C.
Alexander D. McConachie, 1890, Baltimore.
H. E. McConnell, 1890, Chester, S. C.
T. K. Oates, 1896, Martinsburg, W. Va.

J. N. Reik, 1900, Baltimore.
Chas. W. Roberts, 1906, Douglas, Ga.
J. Dawson Reeder, Baltimore.
W. H. William Ragan, 1874, Hagerstown, Md.
C. M. Strong, 1888, Charlotte, N. C.
Harry W. Stoner, 1907, Baltimore.
Isaac S. Stone, 1872, Washington, D. C.
Frederick Snyder, 1908, Rosendale, N. Y.
G. Lane Taneyhill, 1865, Baltimore.
O. Tydings, 1877, Chicago.
J. S. Turner, 1896, Greensboro, N. C.
Randolph Winslow, 1873, Baltimore.
J. S. B. Woolford, 1896, Chattanooga, Tenn.
Wm. E. Wiegert, 1876, Baltimore.
E. A. Wareham, 1883, Hagerstown, Md.

In an oration on "State Medicine and Hygiene," before the American Medical Association, at Atlantic City, June 9, 1909, Dr. John S. Fulton, of Baltimore, advocated national vital statistical laws and condemned the present boards of health, which wait for disease to break out before taking any action.

Dr. Fulton also stated that the United States had neglected to carry out its agreement with the Italian Government to report deaths of Italians in this country, and blamed the failure on the lack of method of the Federal authorities, who, he asserted, are behind the health departments of every other country in the world.

At the recent examination of the State Board of Examiners of South Carolina the following graduates of the University of Maryland passed the examination:

G. C. Bolen, M. D.
M. E. Brogden, M. D.
D. A. Burress, M. D.
W. T. Gibson, M. D.
J. W. McConnell, M. D.
L. A. Risor, M. D.
T. H. Wedoman, M. D.

There were no rejections.

Dr. R. C. Buck, class of 1874, now practicing his profession at Garrisonville, Stafford county, Va., sent THE BULLETIN the following Program of Graduation of his class. It will no doubt be read with interest by the older alumni of the University. Of the class numbering 47 at time of graduation eighteen are known to be dead. Of the Faculty of Physic only two survive—Prof. S. C. Chew and Professor Tiffany, and they are not actively connected with the present Faculty. The Hon. S. Teackle Wallis, Provost, and the Rev. Moses D. Hoge, the orator of the occasion, are dead.

Sixty-seventh commencement of the School of Medicine of the University of Maryland, held at Ford's New Opera House, Baltimore, Tuesday, March 3rd, 1874.

President of the class, W. R. Winchester.

Committees.—Stage Committee (White Badge).—Louis A. Weigel, Chairman; James Brown, H. T. Burgin, W. C. Clande, G. A. Fenton, J. B. Galloway, Gabriel Gimenez, W. B. O'Reilly.—Orchestra Committee (Blue Badge).—C. E. Chamberlayne, Chairman; W. B. Beach, J. H. Crum, J. O. Harrington, C. L. Mitchell, R. H. Smith, B. F Winchester, R. E. Yoe.—Balcony Committee (Blue and White Badge).—F. D. Emack, Chairman; Charles Abert, Jr., J. D. Fiske, E. P. McDevitt, T. E. Murrell, William Rawlings, N. C. Stephens, L. L. W. Tall.

Order of Exercises.—Reading of the mandamus, by the Dean. Conferring of Degrees, by Hon. S. Teackle Wallis, LL. D., Provost of the University. Valedictory Address, by Rev. Moses D. Hoge.

Graduates, 1874.—Howard E. Ames, Maryland; Joseph S. Baldwin, Virginia; Martin B. Billingslea, Maryland; John C. Bryce, South Carolina; Carey Buck, Virginia; Charles T. V. S. Butler, West Virginia; M. S. Butler, West Virginia; C. F. Cairnes, Maryland; D. Lewis, Cheatham, Georgia; Frank Cockey, Maryland; J. Alvan Dawson, Maryland; Amos P. Dodge, New York; Elisha C. Etchison, Maryland; Wickliffe Frierson, Tennessee; F. Denton Gavin, Maryland; J. Edmund Gorsuch,

Maryland; James W. Gurley, South Carolina; Rezin W. Hall, West Virginia; Wm. Nevitt Handy, Maryland; H. T. Harrison, Virginia; Alexander Hill, Maryland; J. Rufus Humphrey, Virginia; J. Lawrence Kelly, Georgia; George S. Kinnemon, Maryland; L. Mervin Maus, Maryland; Charles C. McDowell, Maryland; Wm. J. McDowell, Maryland; Edward S. Miles, Maryland; Robert B. Rorison, Maryland; Elisha E. Mullineaux, Maryland; H. Eugene Norris, Maryland; George T. Perkins, Maryland; Eldridge C. Price, Maryland; O. H. Williams Ragan, Maryland; Wm. M. Reardon, Virginia; Albert J. Remsberg, Maryland; Augustus Riggs, Maryland; Benjamin S. Roseberry, Maryland; Samuel Rowland, Maryland; Thomas E. Sears, Maryland; J. T. Shepherd, Georgia; J. Dawson Smith, Virginia; Benjamin H. Todd, Maryland; George W. Wiener, Maryland; J. Marion Wilkinson, Maryland; Willard H. Wilson, Maryland; Weems R. Winchester, Maryland.

University of Maryland, Hon. S. Teackle Wallis, LL. D., Provost.

Faculty of Physic.—Nathan R. Smith, M. D., President of the Faculty and Emeritus Professor of Surgery. William E. A. Aikin, M. D., LL. D., Professor of Chemistry and Pharmacy. George W. Miltenberger, M. D., Professor of Obstetrics. Richard McSherry, M. D., Professor of Principles and Practice of Medicine. Christopher Johnston, M. D., Professor of Surgery. Samuel C. Chew, M. D., Professor of Materia Medica and Therapeutics. Frank Donaldson, M. D., Professor of Physiology and Hygiene, and Clinical Professor of Diseases of the Throat, Lungs and Heart. William T. Howard, M. D., Professor of Diseases of Women and Children. Julian J. Chisolm, M. D., Professor of Diseases of the Eye and Ear. Francis T. Miles, M. D., Professor of Anatomy, and Clinical Professor of Diseases of the Nervous System. Alan P. Smith, M. D., Professor of Operative Surgery. L. McLane Tiffany, M. D., Demonstrator of Anatomy.

MARRIAGES.

Dr. John Martin Elderdice, class of 1905, of Mardela Springs, Md., was married to Miss Edna Adkins, of Salisbury, June 2, 1909.

Dr. Gordon Wilson, Associate Professor of Medicine, was married the early part of June to Miss Elizabeth Preston Elliott, daughter of Mrs. Elliott and the late Warren Grice Elliott, of 2025 North Charles street, Baltimore, Md. The ceremony was performed in Old St. Paul's Church by Reverend Dr. Arthur Kinsolving. A small reception for the two families and the wedding party followed the ceremony. On their return Doctor and Mrs. Wilson will spend the summer at the Chattolanee Hotel and in the fall will take possession of their new home, 1318 North Charles street.

On April 28, 1909, in Amesbury, Mass., Miss Annie Cunningham, a graduate of the University Hospital Training School for Nurses, class of 1908, was married to Mr. William MacDonald.

Dr. J. Edward Benson, class of 1884, was married June 1, 1909, to Miss Laura Taylor, a teacher in the Hagerstown schools, at the residence of her sister, Mrs. Beachley, wife of School Commissioner Harry K. Beachley, by Reverend Edwin T. Mobray, pastor of St. Paul's Methodist Church. Doctor and Mrs. Benson will spend their honeymoon in visiting points in the North. After their return they will reside at Cockeysville, Md.

Dr. John R. Abercrombie, of Baltimore, was married Wednesday, June 13, 1909, to Dr. Anna D. Schultze, of Baltimore, daughter of Mr. and Mrs. William T. Schultze, also of Baltimore. The ceremony was performed at Grace Protestant Episcopal Church by the Rector, Reverend Dr. Arthur Chilton Powell. Doctor and Mrs. Abercrombie will spend their honeymoon in visiting

points of interest in the North. On their return they will reside at the Netherclift Apartments, 827 Hamilton Terrace.

The marriage of Miss Mary Agnes Browne, of Pittsburg, to Dr. Reuben Alexander Wall, class of 1904, of this city, took place Wednesday, June 16, 1909, the ceremony being performed by Rev. Dr. Van Dyke, Rector of St. Mary's Episcopal Church. The groom was attended by Dr. Edgar Allen Fleetwood, of Savannah, Ga. After an extended wedding trip Doctor and Mrs. Wall will be at home to their friends at Minnifield, Edmondson and Swan avenues, Baltimore.

Dr. Walton Hyde Hopkins, class of 1904, of Annapolis, was married Wednesday, June 23, 1909, to Miss Lila Holmes Trenholm, a graduate of the University Hospital Training School for Nurses and daughter of Mr. Glover Holmes Trenholm. The ceremony was performed by Reverend Edwin Barnes Niver, Rector of Christ Church, at the home of the bride, 713 St. Paul street, Baltimore. Doctor and Mrs. Hopkins, immediately after the ceremony, left for a Northern wedding trip and on their return early in July they will go to their future home in Annapolis.

Dr. Harry M. Robinson, class of 1909, was married to Miss Verna Beatrice Wilson, at Violetville, Baltimore county, Md., May 25, 1909.

DEATHS.

Dr. James H. Thomas, class of 1851, died at his home near Hurlock, Md., June 20, 1909, of paralysis. He was nearly 82 years of age. He was a native of Dorchester county, and the son of the late Algernon Thomas. He was graduated in medicine from the University of Maryland in 1851, and practiced his profession for a time at Smyrna, Del., but finding farming more congenial he moved to his splendid farm near Hurlock. He is survived by a widow, who was a Mrs. Edmondson, of East Newmarket, Md.

Dr. Walter Franklin Fundunberg, class of 1850, surgeon of the 176th Pennsylvania Volunteer Infantry Regiment during the Civil War, died at Atlantic City, November 22, 1908, aged 80.

Dr. George O. Johnson, class of 1869, of Fort Cobb, Oklahoma, a member of the American Medical Association, and a member of the Senate in the First and Second Legislatures of Oklahoma, died in Guthrie, February 10, 1909, from asphyxiation by natural gas, aged 63.

Dr. Richard Evans, class of 1886, of Butte, Mont., died in a hospital in that city, June 8, 1909, aged 53.

Dr. Legare Hargrove, class of 1891, of Nansemond county, Va., died June 16, 1909, in a Norfolk hospital, aged about 36 years. He is survived by a widow, who was Miss Martha Driver, and one daughter.

Dr. Luther Elsworth Zech, class of 1892, a member of the Medical Society of the State of Pennsylvania and of the borough School Board, died suddenly at his home in York, near Salem, Pa., from angina pectoris, aged 47.

Doctor Thomas Perry Robossom, class of 1859, died at his home in Flintstone, Md., May 28, 1909, from paralysis, aged 75.

Dr. Alexander Harmon McLeod, class of 1866, for many years an official of the Cincinnati, Hamilton and Dayton Railroad, died at his home in Wyoming, Cincinnati, May 11, 1909, from pneumonia, aged 63.

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REMARKS ON THE CAUSES AND THE PREVENTION OF PARALYSIS.

BY IRVING J. SPEAR, M. D.,

Clinical Professor of Nervous and Mental Diseases at the University of Maryland.

In the following pages I will call attention to the more frequent causes of paralysis, limiting this term to loss of function of one or more voluntary muscles. I do not wish to convey the impression that these factors are capable of bringing about only motor paralysis, but for the purposes of this paper I have limited myself, in their relationship, to this form of paralysis. I have divided the various causes into six groups and then discussed each group separately. We find the same factors at times in more than one group, these bringing about deleterious results in more than one way; after a summary of the principal causes I have taken up the discussion of the prevention of paralysis, believing as we all must, that in order to prevent paralysis we must first be familiar with the causes, and by preventing and removing these, we may escape the probable sequellæ.

By far the most frequent causes of paralysis are diseases of the vascular system.

Second in frequency are the toxic agents.

Third, trauma.

Fourth, infectious diseases.

Fifth, embryonal.

Sixth, functional.

In discussing diseases of the vascular system that may produce paralysis, we must consider the manifold causes of arterial degeneration and inflammation. Heredity here plays a role, in so far as individuals may inherit a poor vascular system from parents who are tubercular, syphilitic, alcoholic, neurotic, have nephritis or are the subjects of any other long-continued chronic disease. In early life the most frequent cause of vascular disease is infectious in nature, it is as a rule only after the individual has passed the adolescent period, that he is exposed to the various causes of an acquired arterial disease. Of these the more important are syphilis, chronic intoxications, infectious diseases, over work, worry and chronic constitutional diseases.

The vascular system must be affected in one of four ways to be the causative agent of paralysis, or it may be affected in any combination of these. There must be either occlusion of the vessel lumen, rupture, deficiency in the vis a tergo of the circulation, or deformity of a part of the vascular apparatus bringing about abnormal pressure against nerve elements.

Vascular occlusion may be transient,—due to vascular spasm or pressure, permanent due to obliteration of the lumen. The first may be the result of emotion, toxic agents, local irritation or foreign body; the latter is the result of inflammatory or degenerative changes in the vascular wall, foreign body or pressure against the vessel. Under this head come thrombosis and embolus, leading to complete or partial, permanent or temporary occlusion of the vascular lumen.

Rupture of a vessel is due to too great a strain from within or tearing from without. When caused from within, we always have a vascular wall weakened by some pre-existing cause of arterial degeneration.

Those cases due to lack of force of circulation are due to a cardiac condition, loss of blood, shock or vascular relaxation; this may be temporary or permanent in duration.

The fourth cause of paralysis due to a vascular condition is that produced by pressure of a vessel against nerve elements, for example, aneurysm.

These various states of the vascular system may exist in any region of the body, and depending upon the location of this condition, will be the distribution and type of the paralysis.

Toxins to give rise to paralysis must first generally enter the circulation; they may be exogenous or endogenous. The exogenous toxins gen-

erally enter the circulation by the way of the gastro-intestinal tract although a few gain entry through the skin or respiratory apparatus. Certain portions of the nervous system have predilection for certain toxins. The toxin acts by causing inflammation and degeneration of the peripheral nerves and also has a deleterious effect on the central nervous system. Exogenous toxins,—alcohol is by far the commonest of these and has a selective action on the peripheral nerves of both lower and upper extremities, arsenic has selective action for the radial portions of the musculo-spiral nerves, tobacco for the optic nerves, lead for the plexus of Meisner and Auerbach, phosphorous, silver, coal tar products, illuminating gas, carbon bisulphide, etc., all are capable of causing paralysis.

Endogenous toxins-diphtheritic toxin affecting most frequently the pneumogastric nerve, although it may affect any or all the peripheral nerves; la grippe, diabetes, chronic nephritis, gastro-intestinal, rheumatism, tuberculosis, syphilis, malaria, typhoid, typhus, scarlet fever, measles, whooping cough, erysipelas, smallpox, septicemaia, gonorrhoea, etc., are all capable of causing paralysis by means of the actions of their toxins on the nervous system.

These toxins may act directly, affecting either the peripheral or central nervous system, or may act directly upon the vascular system, bringing about degenerative or inflammatory changes in the vessels or heart, this possibly later on may bring about changes in the nervous system which may lead to paralysis; thus showing that toxins may act either directly or indirectly.

Trauma, as a cause of paralysis, occurs at all ages and may affect any portion of the nervous system. From birth when the application of forceps to the foetus is followed by the destruction of brain tissues and rupture of blood vessels, or pressure on cervical nerves causing Ebbs obstetrical paralysis, to the last days of our existence we are constantly exposed to harmful effects from external violence, which may injure either temporarily or permanently brain, cord or nerve and thereby be followed by temporary or permanent paralysis.

Infectious diseases as causative agents of paralysis may act in several ways, the infecting agent itself may directly invade the nervous system, their toxins may do harm at a distance, or either the toxin or infecting agent may involve the vascular system and thus bring about harmful results. The following is a partial list of infecting agents that may bring about paralysis and their manner of doing so:

By means of their toxins—diphtheria, la grippe, typhoid, typhus, scarlet fever, measles, pertussis, malaria, variola, erysipelas, septisemia, pneumonia, tuberculosis, syphilis, etc. By direct injurious effects on the nervous system—anterior poliomyelitis, cerebro-spinal meningitis, syphilis, tuberculosis, typhoid, la grippe, erysipelas, leprosy, beri beri, scarlet fever, smallpox, gonorrhoea, Landry's paralysis, etc. Through the vascular system—syphilis, tuberculosis, typhoid, rheumatism, etc.

Embryonal causes are the result of some abnormality in the development of the foetus which gives rise to an imperfect nervous system, this imperfection manifesting itself by symptoms at birth or under the stress of existence, appearing later in life.

True porencephalus or absence of a portion of the interior of the brain, the defect being occupied by a prolongation of the cerebral ventricle and false porencephalus or absence of a portion or the entire hemisphere, the space being filled with cerebro-spinal fluid, give rise to paralysis affecting one or both sides of the body.

Spinabifida or incomplete development of the coverings of the cord or of the cord and its coverings may be accompanied by paralysis of greater or less extent. The spinal cord itself is sometimes the seat of deficient or defective development giving rise at any period after birth to certain diseases; Freidrich's ataxia due to early degeneration of certain tracts of the cord; syringomyelia due to the development of cavities that were incompletely obliterated during foetal life.

Functional causes are those to whose action we are, as yet, unable to refer a demonstrable lesion. They bring about their results by interfering or inhibiting the normal co-ordinate activities of the higher psychic centers. Fear, suggestion and autosuggestion are the most important and most frequent acting functional causes which are followed by paralysis.

The old adage that an ounce of prevention is worth more than a pound of cure may very well be applied to the prevention of paralysis, as this

is very frequently difficult or impossible of cure after it has occurred, whereas by taking proper precaution it may often be altogether avoided.

The embryonal causes, deficient and defective brain and spinal cord formation may generally be avoided, if only those beget children who are physically and mentally healthy, who are free from hereditary taint, who are living a rational life, if proper care of the pregnant mother is taken, if she is guarded from harmful influences, well nourished, have proper diversions, good hygienic surroundings, and proper medical supervision during the pregnant period.

The injuries that may occur during delivery may be minimized by competent medical attention and if they occur should be promptly and properly treated. If the child has escaped the dangers of foetal life and of the journey into this world, it will now be exposed to the harmful effects of trauma, toxins and infection. Trauma should be guarded against by careful supervision, toxins and infections by proper regulation of the diet, this at least if it does not guard the child against toxins and infection, places it in better condition to resist their effects. If evidence of intoxication or infection occur the condition should be properly treated under competent medical supervision, for even the mildest of these conditions may be followed by serious consequences.

With few exceptions, until early adolesence, the child is exposed only to those deleterious factors, that the parents alone can guard against and foresee—heredity, trauma and infection. As youth ends, and early adult life begins, temptations assail the young aspirant, he is exposed to the dangers of toxic subjects and venereal infection, woe to him if he succumbs, for he has opened the portal to the enemy, who once having gained admission is difficult to dislodge. If he has yielded to the lure of the drug or acquired venereal disease, he must be promptly and properly treated, thereby avoiding later prolific sources of paralysis.

Excesses of eating, drinking, emotion, physical and mental work, etc., should be shunned or a beginning vascular disease may be inaugurated with its later serious consequences.

There should be proper medical supervision in all cases of illness. As old age comes on, as it must to all, who has escaped life's earlier battles, if we would avoid its evident dangers we must live a life ordered to avoid their causes; sudden movements, constipation, over eating and drinking, unwise exposure to the elements, worry, violent physical exertion, neglect of physical and mental ailments, etc.

In conclusion I would advise the observance of the following general rules for the prevention of paralysis:

The begetting of children only by healthy parents, proper care of the pregnant mother, and competent medical attention during confinement.

The proper feeding of the infant, good hygienic surroundings and prompt medical attention to all ailments.

Guarding as far as possible against trauma, infectious diseases, etc., and the prompt treatment of all diseases.

Early supervision of the eyes, ears, nose, throat, teeth, etc.

A good moral, intellectual and physical education. Moderation in all habits; eating, drinking, working and playing.

Avoidance of unwise exposure to the elements.

The cultivation of a peaceful and contented disposition.

THE TREATMENT OF CYSTITIS IN WOMEN.

By I. S. Stone, M. D., Class 1872.
Washington, D. C.

A very common disease may be easily overlooked and a patient have an incurable disease of her bladder because her symptoms were allowed to continue while *medical* treatment is instituted without *direct* examination. In my ward visit in one of the hospitals with which I am connected, two patients were recently turned over to my service from the medical service. They well illustrate my object in writing this paper, and I shall allude to them to show what is meant by my opening remarks.

Mrs. A., aged 14, had been having slight fever for several weeks. She had pain in the region of both kidneys and back and had lost several pounds in weight. She had frequent mictura-

tion and a deposit of white sediment in her urine. Examination of her urine was negative, save for epithelial cells and leucocytes. She had taken urotropin, diuretics, tonics and laxatives, etc., for several weeks. A pelvic examination had not been made. Our examination disclosed thickened bladder walls with greatly diminished capacity—not over four ounces. This poor woman probably has tuberculosis of one or both kidneys, with secondary ulceration of the bladder.

The other case was in a colored woman, 60 years of age, who had also been in the medical service of the hospital for several weeks. She had been unable to retain her urine, and was suffering from excoriation and other annoyances incidental to a constant leakage. She had also taken "urotropin" (the sovereign remedy for bladder disease) and was no better after her residence in the hospital than before. This patient had a bladder capacity of less than two ounces, and her bladder felt like a flabby uterus between the examining fingers. Its mucosa was thick and soft with deep red color and somewhat ulcerated and incrusted with the usual deposit of ammonia phosphates only seen in belated and neglected cases.

This case appears not to have tuberculosis, but merely a neglected bladder from local causes. It would be nothing more than right to quote from the prescriptions given this patient to show what our therapeuticians recommend for a supposed "weak bladder," or weak "sphincter meatus urinæ." Such prescriptions when printed alongside the findings in a case such as is now being described would indeed be illuminating. But I forbear and will now speak of the methods which have given the best results to be obtained in such cases.

Examination. We can never be excused for omitting an examination when a disease may become chronic and possibly incurable for the want of it. Nearly all the cases of acute cystitis are easily curable by direct treatment by bladder irrigation, distension and sterilization. Therefore, we repeat this injunction to urge the necessity for early and proper treatment. It would be well for every female patient in the medical wards who is passing urine frequently to have an examination by a gynecologist. The medical men (the internist) will not practice the touch, and hence cannot and in fact frequently do not know all that is to be learned by a pelvic examination. For instance in the ward cases above mentioned the routine urinary examination will show the presence of leucocytes" and "epithelium." There may be no estimate of how many leucocytes, or of what is now often neglected in such examinations, the quantity of mucous found in the specimen, nor will anyone know the capacity of the bladder. If this urinary examination is supplemented by a cystoscopic investigation, there is frequently enough found to explain all of the urgent symptoms. But we must excuse the internist for not appreciating all of the possible findings in one of the neglected cases. There may be very interesting complications present. One never knows what may be found to explain a given case. We have found annexal disease most frequently to explain the presence of cystitis in women although many other causes are frequently seen. Calculi in the bladder or ureters may be present as persistent irritants, and their presence should always be in mind. The enlarged and thickened ureter found in either renal or bladder cases, may be palpated in those cases which are not associated with great thickening of the bladder walls, and a stone in the lower end of the ureter may be located, and afford an explanation of persistent cystitis. Obviously we cannot palpate the ureters when there is associated salpingitis or any induration or other abnormal conditions present. To palpate the normal ureter is generally impossible, except in very expert hands, but it is comparatively easy to find a stone in the ureter if it is near the bladder, provided there is no great disease of the various organs in the pelvis.

Treatment. A cardinal principle is to always learn the extent of the lesion in any case, but in these cases our most important duty is to measure the capacity of the bladder. Frequent micturition means one of two things as a rule, either a very sensitive nervous bladder or one contracted from cystitis. In view of the urinary examination one should easily be distinguished from the other. One thing is evident and most important, namely, that the contracted bladder cannot be cured of cystitis until it is dilated and sterilized. We often tell our internes that it is quite

as impossible to treat a lesion of a closed hand without opening it, as to attempt to cure a bad cystitis without distending the bladder. Therefore we must first of all fill the bladder perhaps three or four times with normal salt-solution, or, better still, boric acid solution, using all that the patient will bear. The capacity can be measured each time the bladder is emptied, and it will be found that the bladder will often contain a few ounces more at the end of the treatment than at the beginning. We use 2 oz. protargol solution at present, because it is less irritating than silver nitrate, and allow the patient to retain this in her bladder until the next urination. It is our routine practice to use protargol after the catheter period in any pelvic operation, before the patient leaves the hospital, as we may expect to find a small amount of pus in the urine of all such patients, and indeed we know of several persistently annoying cases resulting from a neglect of the above precaution.

To summarize: We would urge a careful pelvic examination in all cases where there is frequency of micturition with pus or epithelium in the urine, whatever may be the condition of the patient. We would demand that the capacity of each bladder be measured as a preliminary to regular treatment and we consider this of greater importance than a cystocopic examination, save in the most expert hands. After the patient has improved, and her condition permits a proper cystocopic examination, the results will not only be less painful, but the findings more satisfactory.

STRICTURE OF THE ESOPHAGUS.

By Richard H. Johnston, M. D.,

Lecturer on Laryngology in the University of Maryland; Surgeon to the Presbyterian Hospital; Consulting Laryngologist to St. Joseph's Hospitad; Consulting Laryngologist to the General and Marine Hospital, of Crisfield, Md.

June 15, 1909, Mrs. J. H. M. was referred to me by Dr. R. P. Bay. Her history briefly was as follows: More than 2 years ago she experienced great pain on swallowing, which was located about 2 inches above the cardia. At times the suffering was so intense, she would almost collapse. Not long after the attacks of pain had disappeared, she noticed that the swallowing of solid food was becoming more and more difficult, until finally she was able to take only liquid diet. When I saw her she had eaten no solid food for 2 years; she lived on milk and was well nourished. In the sitting position and with the head extended 20 per cent., cocaine solution was applied to the throat and esophagus. Examination of the upper end of the esophagus revealed nothing pathological. The 10 mm. esophagoscope was then passed and the walls of the esophagus carefully examined. About 2 inches above the cardia a complete stenosis of the esophagus was found. No opening could be seen, so a fine probe was passed through the esophagoscope and careful palpation of the cicatricial tissue made. The probe finally located the opening; the smallest Bunt bougie was then passed through the esophagoscope and the stricture dilated under the guidance of the eye. Two more Bunt bougies, larger in size, were passed in the same manner until the dilatation had reached 7 mm. Two days later a wax and fibre bougie was gently passed through the stricture. Aside from slight soreness in the cardiac region the patient presented no symptoms. On the fourth day she swallowed solid food with practically no trouble. The soft bougie was passed daily for a few days. One week after the first dilation the esophagoscope was again passed, and instead of an impermeable stricture, we found an opening nearly half an inch large with walls almost healed. The patient was taught to pass the soft bougie and was sent home June 26th, able to swallow everything. She will continue the treatment at home gradually lengthening the intervals between the bougieings until one passage monthly will be sufficient to keep the opening patent. She had been treated for months by the old method unsuccessfully and had given up hope of any improvement. It is probable that she would eventually have closed entirely and

a gastrostomy would have been necessary. The cause of the stricture was probably an ulcer of the esophagus which, in healing, gave rise to the cicatricial contraction. The result in this case was brilliant as compared with a gastrostomy. Bunt's bougies are most valuable for dilating strictures. They are made with two olive tips about 1.5 inches apart. The smallest bougie has an end tip no larger than a fine probe, so that after the opening is located it is used as a probe and as a guide for the larger olive. Once through the stricture with the small tip, force can be applied to the second olive with no danger of making a false passage. Since everything is done through the esophagoscope, the operator sees every step of the treatment. It is obvious that the danger of making a false passage is practically done away with. After the stricture is dilated to 7 or 8 mm., it is safe to pass the wax and fibre bougies in increasing sizes. The most difficult part of the treatment is the first dilatation and this is made easy through esophagoscopy.

A CASE OF PYLORIC CARCINOMA.

By Robert H. Gantt, '09.

Senior Medical Student.

Patient a white male, Spaniard by birth, is of a small stature, but fairly well developed, 60 years of age. His past history is negative, as he does not remember having had those diseases incident to childhood and as well as he remembers has always been a healthy individual. There is nothing in his family history pointing towards his present trouble.

Present illness: About June, 1908, he began vomiting almost every time he would eat. The vomitus was irregular in quantity, at times followed by considerable retching, but never at any time containing any blood.

His first signs of pain would come on following attacks of vomiting and at first were felt in the upper abdominal region just to the left of the xiphoid cartilage. From this point it spread laterally and over lower abdominal regions. The pains are of a sharp and intense character. He is constipated, and it is necessary to purge him daily. Pain is of a much less intensity following the use of cathartic. Bowels were regular before the onset of this present illness.

Examination reveals an irregular nodular, movable lump in the region of pylorus. Patient states that this lump seems to disappear after attacks of nausea. Hepatic dullness is increased inferiorly. Appetite is poor.

Has lost considerable weight, his present weight being 103 lbs. Skin is of dry, yellowish look, presenting evident signs of cachexia and emaciation. Facies are those of one worried and anxious. Examination of heart, lungs and kidneys negative, arteries are somewhat sclerotic, but the pulse is regular in tone and rythm and its volume is good.

Urine: Clear, sp. gr. 1026 React. acid. Albumen, sugar, Blood, negative. Sed., scant, containing a few renal epithelial cells and amorphus urates.

Blood: Leucocytes 8,600.

Erythrocytes 4,800,000. Haemoglobin 70%. Stomach contents. Total acidity 56 degrees. Free H.C.L. 0.0876%. Microscopic examination shows an excess of starch granules, but no Oplen Bras bacilli and no sarcinae.

Temperature upon admission, 97.4 F., pulse 60 to minute, respiration 18.

Diagnosis: Pyloric carcinoma. Patient entered hospital on October 12, 1908, and was ordered for operation the morning of 14th. Nothing by mouth was given for twelve hours preceding and the stomach was lavaged on the morning of the operation.

Operation: Operator, Dr. F. Martin; Assistant, Dr. Lynn; Anaesthist, Dr. Richards; anaesthetic, ether.

Patient was carried to operating room, and prepared for an aseptic operation, abdomen being scrubbed with green soap, sterile water, alcohol, ether and bichloride. An incision was made opening the upper abdomen, in median line—incision about eight inches in length. The stomach was markedly dilated and at the pyloric orifice a large malignant growth, carcomatous in character was found. The vessels supplying the pylorus, viz: the gastric, pyloric, gastro-epiploca dextra and pancreatic duodenalis superior were

ligated with linen thread and cut. The pyloric ends of the stomach and duodenum were then freed from their mesenteric attachments and the ends of the pylorus and duodenum at a sufficient distance above the growth were tied with heavy tape to prevent the escape of contents into the peritoneal cavity. Purse-string sutures were inserted at these locations where sections were to be made and the cancerous growth removed. The free ends of the duodenum and stomach were cauterized with pure carbolic acid and washed off with alcohol and invaginated, the purse-string sutures being tightly tied, and reinforced by a continuous Lembert suture. The tape ligatures were then removed from the bowel and stomach. Next a posterior gastro-jejunostomy was done, a hole being torn through the transverse meso colon and the jijenum being sutured to posterior stomach wall about 1½ inches above the greater curvature and 3 inches from the pyloric stump. The jijenum and stomach wall were held tightly with Monihens clamps, the anastomotic incisions made, and sutured first with the Connell, and then reinforced with continuous Lembert sutures of fine black silk. The fore end of the duodenum was then sutured to the mesentery. All packs and gauze packing were then removed, the peritoneum and fascias closed with fine black silk and the wound closed with a subcutaneous silver wire suture. Silver foil and stock dressings were applied and the patient returned to his room in fair condition, he being slightly shocked. During the operation strychnine was administered to the extent of 1/15 of a grain and immediately following a rectal infusion of normal salt was administered, and ordered g. four hours, strychnine 1/30 g. four hours.

Following the operation the patient had some slight reaction, but this soon subsided, temperature and pulse remaining normal. Nothing was given by mouth until second day following, when small quantities of albumen water were allowed. The patient was resting well and stimulation was discontinued on the second day following operation, as was also the rectal infusion of normal salt solution.

About one week subsequent to the operation, he complained of pain and tenderness upon pressure at the upper extremity of the wound. Palpation revealed a sense of bogginess and it was thought there was a collection of pus in this location due to leakage from the stomach. There was a slight rise in temperature. Three days later the collection worked itself to the surface and the abscess evacuated itself. A small rubber tube was inserted for drainage. The temperature and pulse immediately fell to normal and remained so.

On October 26, or twelve days following the operation, he was allowed a special soft diet, consisting of soft toast, milk and broths; two days later he was given potatoes and allowed port wine, twice daily and permitted to sit up. His condition continued to improve and three weeks following the operation he was allowed to walk and partake of a generous diet. He now weighed 105 lbs. The abscess tract at upper end of wound was rapidly filling in and he seemed in good condition.

On November 1, 1908, the patient was discharged. Wound had been closed for five days and his general condition had very much improved. During his last week in the hospital he had gained 6½ lbs. in weight, and his condition is quite a contrast to that of five weeks ago upon entrance. Instead of discontent, distress and evident unhappiness and anxiety, he now is cheerful, contented and comfortable. His general condition is decidedly better and he is partaking of a liberal diet, with no discomfort.

This patient was heard from about February 1, and was doing well. He had returned to his work, that of a cigar maker, and was suffering no discomfort or distress. In his own words, he was very happy and enjoying life.

DIAGNOSIS IN CHILDHOOD.

By Nathan Winslow, M. D.,

During the first few years, the physician has to rely upon the objective signs of disease, for the child is unable to describe its subjective symptoms, but the two following fundamental principles are of great assistance in arriving at a proper diagnosis; on the one hand it is a well known fact that pathological processes at this period of life are practically limited to the gastro-intestinal tract, the lungs, and the brain; and on the other hand owing to the extreme susceptibility of the nervous mechanism of infants, functional derangements are often accompanied by very grave symptoms, and may even prove fatal in twenty-four hours, or there may be speedy and complete recovery after very alarming symptoms.

In seeking a diagnosis, it is best to start with the history which may be obtained from the mother, after which a methodical physical examination is in order.

History.—The previous, as well as present history of the child should be minutely investigated. The nature of the delivery, whether normal, instrumental, tardy, or precipitate, is an extremely valuable aid to diagnosis. In disturbances of nutrition not only enquire about the nature and amount of the food given, but also how prepared. Do not fail to ascertain whether the child has been gaining or losing weight. Investigate the time of the eruption of the teeth. Ask at what time the child began to stand and walk alone. Make it a point to ascertain the acute infectious diseases the baby has had. Find out the time of onset of the present malady, and how it was ushered in. Ask, if the temperature has been elevated; if there has been any cough; if there has been any evidence of pain. Observe whether the child is restless. Investigate the character of its sleep. The bowels should not be overlooked, learn whether they are constipated or loose, and the number and amount of the stools passed in a day. The amount of urine and the frequency of micturition should be fully ascertained. Question the parents, in case of suspected congenital syphilis, about their previous life.

Physical Examination.—In order to make a thorough examination, our ingenuity, time, skill, perseverence, and tact are taxed to the utmost, before the desired information is obtained. In going over a case, exactly the same method of procedure is followed as in the adult. Begin with an inspection of the different regions of the body, palpation, percussion, auscultation, and the various instruments of precision have their fields of usefulness, but in any case patience, tact and time are essential to a proper and thorough examination.

Inspection.—Bare the part to be examined, even without touching the child, especially if asleep; very important information can be gained. If the child is asleep, note whether it lies on its face or back. In cerebral involvement it may be in a position of opisthotonus. Note whether the sleep is quiet or disturbed, whether the respirations are normal or abnormal, whether there is an eruption on the body, whether there is athetosis. Palpable deformity is obvious.

Skin.—The color of the skin should not be neglected for it often gives us important clues to the pathological process going on. In anemia one is struck by the extreme degree of palor. In chronic indigestion the skin takes on a peculiar hue, and is often wrinkled from absorption of the subcutaneous fat. A bluish tinge of the lips or a cyanosis of the extremities should direct our attention to the heart, or lungs, and is due to a sluggish capillary circulation. In obstructive diseases of the upper air passages, the patient takes on a leaden color. In shock the skin is pale, cold, and clammy. In the eruptive diseases the skin is of the utmost importance in diagnosis.

Attitude.—A healthy child, when not asleep, should be more or less constantly in motion. When you encounter a child over six months of age not active, it in all probablity, is suffering from malnutrition. When a child eighteen months of age does not walk, you should think of rickets as being the probable cause. If upon inspection a

joint is found in semi-flexion, you may be certain an inflammation is present. If the child is suffering from a unilateral pneumonia, it will lie upon the affected side, which upon inspection will be found to be motionless. In diseases of the circulatory system, the posture is of great importance as a guide to diagnosis. In cardiac dilatation a semi-flexed sitting posture is assumed. In deep seated abdominal inflammations the patients lie upon their back, the muscles are rigid, and the thighs are flexed on the pelvis, and the legs upon the thighs. In meningitis, when the intellect is affected, the child will lie in bed in one position. Whenever you see an arm drop helplessly as in the dissecting room, there is an extreme degree of intoxication. In Pott's disease the posture is very characteristic. In children many of the acute infectious diseases are ushered in by convulsions. If these occur at the onset of the malady, they are not as serious as those which take place at the termination of the illness.

Movements.—There is a group of diseases (nervous) whose presence is indicated by certain movements. In tubercular meningitis the head is continually turned from side to side, and the hand at the same time is carried to the head. In case of hunger the babe grasps at everything within reach, and is constantly putting its hand to its mouth. It should be borne in mind that in many chest diseases, the patient will rub its abdomen.

Cry.—The cry of the child is of considerable importance as an aid to the diagnosis of quite a number of diseases. One should be able to recognize whether it is due to anger, pain, habit, hunger, etc. Do not say the child hasn't pain, if there are tears, for they are not present before the second month. The cry of hunger is not sharp or piercing, but is long continued, and the hands are continually carried to the mouth. The cry of pain within the first two weeks of life. In this case the cry is loud, and prolonged; the body of the child is stiffened; the head is thrown back; and the child kicks violently. Extreme degrees of exhaustion are characterized by a low, feeble whine or moan. The cry of habit is very difficult to recognize, but can be told by the child ceasing to cry, when its wants are satisfied.

Certain diseases have characteristic cries, as the short, catchy, suppressed cry of pneumonia; the sharp nocturnal, hydrocephalic cry of tubercular meningitis; the hoarse, nasal cry of congenital syphilis; and the suppressed muffled cry accompanying atelectasis.

Vomiting is very much more frequently observed in childhood than later in life, and has not the same significance. Owing to the more vertical position and size of the stomach food in overdistention is very frequently regurgitated. Gastro-intestinal affections are sometimes cured by vomiting. The act of vomiting often serves as an indication of beginning infectious diseases, such as, scarlatina, measles, lobar pneumonia, which later in life are ushered in by a chill. Vomiting is sometimes an indication of nephritis. In cases of peritonitis and appendicitis, vomiting occurs as a very early symptom.

Mouth.—The mouth and tongue are often characteristic of certain diseases, e. g., measles, etc. Lesions of congenital syphilis make their appearance on the mucous membrane of the cheeks. The tongue likewise gives us important information about changes occurring in the body. In many of the diseases of the stomach and intestines the tongue is dry and shows a tendency to crack. In exhaustive diseases, it is coated with a whitish, yellowish, or brownish debris. In scarlet fever we have the strawberry tongue. In nervous exhaustion it often is very much swollen. One of the cardinal signs of scurvy is the swollen and hemorrhagic condition of the gums.

Throat.—Never omit an examination of the throat. Look on the hard palate for the eruptions of the acute infectious diseases.

Stools.—Never neglect to inspect the stools yourself in bowel complaint, as some important information may be derived by this procedure. Pure blood is seldom passed by these tiny patients, it is due to hemorrhoids, to which children are exempt, or to some obstruction of the lower bowl. In enterocolitis you have blood mixed with mucus in the fecal mass.

Urine.—The urine should be subjected to the same tests as adults, and the physician should make it a routine practice in every physical examination

to examine this secretion. In the male it may be collected in a condum, in the female in a cup fastened over the vulva.

Pulse.—Changes in the rhythm of the pulse are not so significant as later in life. See if it is rapid or slow; full or strong; soft or compressible. A slow, irregular pulse often suggests meningitis.

Heart.—Acquired organic heart disease does not as a rule appear until the third year. If loud murmurs are heard, they are almost certainly of congenital origin, soft ones are functional.

Respirations.—Changes in rhythm of respirations are not so significant as later in life. Note, whether it is regular or irregular; whether slow, rapid, easy, quiet, snoring, or normal. Mouth breathing may be caused by tonsilitis, adenoids, diphtheria or any congestive affection of the nasal passages.

Temperature.—In making an examination of a child, always ascertain whether fever is present. To get this properly, do not rely upon the mouth or axillary method, but take it per rectum. The average temperature of the child is 99° F. Nervous, high strung children are prone to take on fever on the slightest provocation. This rise is due to a functional disturbance, and subsides after a few hours. Underfeeding is followed by a rise in temperature. The temperature of premature children is often subnormal, but can be raised by artificial means. Pulse rate and tone are of more importance than the range of the thermometer.

Facial Expression.—Note whether the features are calm, or drawn and anxious, intelligent or stupid. Pain frequently manifests itself by contraction of the facial muscles.

Cough.—Carefully ascertain whether the cough is constant, barky, croupy, light, loose, or severe; and the nature of the sputum expectorated should not be overlooked.

Eyes.—If the mother has a vaginal discharge, the eyes should receive careful attention, else they may give great trouble and anxiety. Ascertain in an examination of these organs, whether the pupils react to light, and whether they are dilated or contracted. Interstitial keratitis indicates the presence of congenital syphilis.

Nose.—Any nasal discharge should be carefully noted. If acute, suspect diphtheria, scarlet fever, influenza; if chronic, the most likely causes are adenoids and syphilis.

Abdomen.—Look for tympanitis and points of tenderness. Note whether the abdomen is retracted as in meningitis. Try to palpate the different abdominal viscera, for the liver and the spleen are sometimes found to be displaced, especially, in contractions of the chest due to rickets. In acute diseases an enlarged spleen suggests malaria, typhoid fever, tuberculosis; in chronic maladies, malaria, syphilis, and leukemia.

Bones.—Be sure to note any enlargement of the osseous structure and always look for points of tenderness.

Skull.—Determine by running the fingers over the head, whether the fontanelles and sutures are opened or closed.

Glands.—Enlarged cervical glands may be due to acute tonsilitis, diptheria, measles, etc., so do not fail to examine them when going over a patient, as they may guide us to a proper diagnosis.

General Condition.—Observe whether the muscles are flabby or well nourished; whether there is any deformity of the bony system. Investigate depends upon its severity. It is sharp and piercing, the features are contorted, and there are other signs of distress. The cry of temper is present sight, speech, and general mental development. If the child is able to tell its symptoms, do not try to obtain the facts desired too quickly.

Palpitation.—The hands must be warm. We rarely fail to get the fremitus of the cry, and this is usually great, due to the thin walls. Mucous in tubes will be indicated by a rhonchial fremitus, and is significant of bronchitis. Locate apex beat of the heart, which is usually in fourth intercostal space.

Percussion.—To percuss the back, have the nurse rest the child over her shoulder. Owing to the thin chest walls, and large bronchi the percussion note is rather tympanitic, and is exaggerated on the right side.

Auscultation.—Auscultate the posterior chest wall first as the child is not so apt to be frightened, also because evidence of disease oftentimes first makes its appearance here.

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THE SOUTH'S PROSPERITY. THE OPPORTUNITY FOR EDUCATIONAL INSTITUTIONS OF BALTIMORE.

The marvelous natural resources of the South summed up by Mr. G. G. Dawe in an address delivered at the meeting of the Southern Commercial Secretaries' Association, Atlanta, Ga., recently, almost stagger the imagination of people who have not investigated the great possibilities for development in the agricultural and commercial growth of the Southern States. Mr. Dawe shows that the South has the largest area of workable land awaiting agricultural development of any section of this country; that she has 11 per cent. of the standing timber of the United States; of navigable rivers to the total mileage of 26,410 miles, the South has 18,215 miles. She has 3,000 miles of coast line, while the Atlantic and Pacific Coasts combined have only 2,100 miles. She has thriving ports, which when the Panama Canal is opened, will present enormous opportunities to trade with the South American countries. The Southern people are fast awakening to a realization of the possibilities of development of these vast resources in manufacturing, mining and agriculture. She is forging ahead with marvelous speed.

In matters of education the Southern universities, colleges, public and private schools are growing in like proportion. Baltimore being the leading metropolis of the South, should be made a center of her educational interests. By reason of her population, her climate, her social advantages, she presents facilities for educational training not possessed by any other city in the South and not surpassed by any city in the North.

Baltimore should be made a great educational center and it would be wise upon the part of our educational institutions to reach out after students from the South. They can find in Baltimore opportunities which cannot be found in other cities. These facts apply with special force to the medical schools of our city.

We have in Baltimore six medical schools now in active operation and educating over 1,500 medical students. It will be an easy matter for these institutions to double the number of students from the South as well as from the North, if the advantages of education are properly presented to the large body of young men who are seeking an education in medicine. The medical schools of Baltimore possess unusual advantages for scientific and clinical instruction. With hospitals and laboratories well equipped for instructing students, with teaching bodies well organized and trained for giving instruction, it is possible to give an education in medicine that will equip the medical student for the highest work in his profession.

It remains for the institutions of this city to present in a forcible way, the opportunities which they can offer to the medical student and the BULLETIN is of the opinion that those institutions which get in line and make good in their work of instruction will prosper through the opportunities which will be presented to them.

Baltimore possesses a climate, a social life and all the desirable features which should make the residence of the student here a profitable one. The amount of clinical material to be found in our larger hospitals, if fully utilized, could be made to give two-fold the amount of instruction which is now derived from it.

In reaching out after students, it would be well for the medical institutions of Baltimore to emphasize the fact that clinical teaching and laboratory instruction can be found here in the greatest abundance.

The immense development of the South's material wealth is Baltimore's opportunity. Her commercial bodies realizing the source of the South's vast wealth, are using every effort to attract attention to this city as a manufacturing and distributing center. Why should not medical schools of this city realize the position which they enjoy and organize with the same purpose in view?

THE ANNUAL CATALOGUE FOR SESSION, 1909-10.

The annual catalogue recently issued by the Dean of the Faculty of Physic of the University of Maryland presents a general statement of the work in the Medical Department during the past session and an announcement of the course for the coming session.

Whilst few changes have been made in the work proposed, the report for the past session shows many evidences of progress.

During the session there were 329 medical students in attendance, of which number 89 received the degree of Doctor of Medicine. Forty members of the present fourth year class were appointed clinical assistants to the University-Hospital. The Hospital staff now numbers fourteen assistant resident physicians, surgeons, obstetricians and pathologists. The Training School for Nurses numbers 64. During the year 1908-1909 4,947 patients were treated in the University Hospital, while in the outdoor department 31,423 patients were treated. This rich field of clinical material was used in the clinical instruction of the students in attendance.

In the Maternity Hospital of the University 235 indoor confinements were attended and 448 outdoor, a total of 683 cases, making an average of 33 cases of labor seen by each student of the graduating class. In addition to the above the students of the graduating class received instruction in Bayview Hospital, Hospital for the Relief of Crippled and Deformed Children and Presbyterian Eye and Ear Hospital.

THE BULLETIN doubts whether any medical school in this country can offer to its graduating class larger or better facilities for clinical work and instruction than the University of Maryland. In this field she stands ready to show results or to institute comparisons. The future of the University was never more encouraging than it is today. Her plant and organization are keeping pace with every requirement of a great clinical school. The spirit of harmony and progress is the spirit of her teaching and student bodies. All are striving to do efficient work in imparting and in receiving instruction. These statements are not made in a boastful spirit, but with an honest desire to assure the alumni of the University who have few opportunities of visiting their old Alma Mater just what she is doing and how far she is making good her claims upon them for respect and co-operation in her work.

CORRESPONDENCE

SANTIAGO DE LOS CABALLEROS,
REPUBLICA DOMINICANA,
July 1, 1909.

DEAR MR. EDITOR:

Presuming that you might have a small corner in your interesting little BULLETIN, I am sending you a report of one of several cases of "Tetanus," that has recently fallen to my lot, and that may prove of interest to your readers.

Tetanus is very prevalent in this country and as in all countries has a high mortality, the treatment only makes us realize how little we can accomplish. My own experience with the serum as a curative measure has been anything but encouraging. Perhaps the serum supplied has been at fault. Certainly the conditions in the tropics are not favorable to its preservation for any length of time. Some months ago I had heard or read of the use of sulphur in Tetanus, and resolved to try it. Since using this drug I have had five good cases to attend, three of which are still alive; in the other two cases the patient had been neglected until too late to derive any benefit from any treatment. I will cite one of my successful cases. On Feb. 12, 1909, I was called from Santiago to Laguna Salada, a distance of 45 miles, to see a young man with "spasm." On arrival I found the patient surrounded by several friends, struggling fearfully. Gradually I got the history of a cut foot following a bath in the river. Ten or twelve days later began to have attacks, gradually growing in violence until at the time of my arrival the attacks were about every twenty minutes and very violent. All the muscles of the body involved, and the patient during the attacks very violent, it being necessary for two or three men to control him. His arms especially were involved and the set of the jaw muscles gave the characteristic "Risus Sardonicus." After each spasm the poor fellow would show how completely exhausted he was. Although the spasm was over, his muscles still retained some rigidity and he perspired profusely. He had one degree of temp. In these countries when a man's impedimenter is crowded in his saddle bags, the opportunity to confirm one's diagnosis microscopically is denied you. But hav-

ing seen so much of this condition, I feel sure of the diagnosis. I immediately confiscated all the "Mauteca," or native butter in the hut, and roughly made up with ℥ii of sulphur precipitate and ½ a lb. more or less of butter an ointment, and picking out two strong young men started them to work rubbing the ointment into the chest, abdomen, loins, groin and axillae; as these fellows tired two others continued the rubbing, resting only at the spasm. Every two hours I gave one teaspoonful of sulphur precipitate in a little milk, by mouth. Leaving my directions thus, I slung my hammock in a neighboring booeja, I slept for four hours. On awaking I was informed that the attacks had been less frequent and weaker, lasting a much shorter time. This treatment was kept up for fifteen hours, at the end of which time he had passed three hours without attack. His body muscles were almost completely relaxed and he was dozing comfortably. The last attack had been very feeble. I reduced my treatment. ℥i prec. sulphur every four hours, in milk and left him. His recovery, I was later informed, was rapid—in several days he was up and out.

This is one of three cases treated with sulphur. The two fatal cases I mentioned had been for days without treatment (except the native witch doctor), and were not fair cases.

CHARLES HARDWICK, M. D.,
Class of 1904.

THE OPENING OF THE GENERAL AND MARINE HOSPITAL AT CRISFIELD, MARYLAND.

CRISFIELD, MD., June 30th, 1909.

To The HOSPITAL BULLETIN:

Crisfield is the southernmost town of any considerable size in the State of Maryland. Its population is approximately 5,000 people, and there is perhaps another 5,000 within an area of 5 miles. It is a port of entry of the United States and it is said that the number of vessels registered at this port is exceeded but by two or three other ports in the country. Although it has a large number of vessels, they are of small size and light tonnage. The chief industries are connected with the water and consist of crabbing in the summer and oystering in the winter. It is said to be the largest crab market in the world. Owing to these industries a large number of men are employed who come from all parts of the country, and until the present time there has been no adequate provision for the care of these people when sick and injured, and hitherto they have been treated at their homes by the local physicians or sent to Baltimore or to other cities where hospitals are located.

Today is a red letter day in the history of Crisfield for it marks the fruition of plans that have long been in preparation for the establishment of a hospital in this city. The General and Marine Hospital was dedicated today and will soon be opened for the reception of patients. The Hospital will be under the professional care of the physicians of Crisfield and of Somerset county, but a staff of consulting physicians and surgeons from Baltimore will assist them in their work.

In company with Drs. J. Fred. Adams, J. M. Craighill and Nathan Winslow, I attended the opening ceremonies of the Hospital. A large company was present from the town and surrounding country as well as from more remote points and the board of lady managers served an elaborate entertainment for those who were present. Dr. Gordon T. Atkinson presided and introduced the speakers. The Governors of Virginia and Maryland were both expected to be present, but neither of them put in an appearance, consequently their places in the program had to be filled by others, and I believe I was the substitute for the Governor of Maryland. In fact, it seemed to be my lot to be mistaken for the Governor, as when Dr. Craighill and I walked up the street at Crisfield, we met an elderly man leading a brindled bull dog, named Mike, who inquired: "Is any one of you gentlemen the Governor?" Perhaps, however, he thought Dr. Craighill, with his dignified manner and impressive bearing to be the Governor, and I only the Secretary of State?

The Hospital is situated on the main street of the city and consists of a two-story building which is very well adapted for the purposes to which it is devoted. It will have accommodation for about 20 patients and has been well furnished with beds and other necessary fixtures as well as with the necessary equipment of a modern operating room. Crisfield is to be congratulated upon having this institution for the care of its sick and suffering, for not only will it be a boon to those who seek entrance into its wards, but it will also be a great educational factor in the training of the physicians of the town and county, as well as a center from which important hygienic and sanitary information will be disseminated amongst the people.

As in other portions of the Eastern Shore, hospitality reigns supreme, and during our stay in the town every possible courtesy and attention was shown us. Crisfield may be reached by steamboat, leaving Baltimore about 5 o'clock in the afternoon and reaching Crisfield very early in the morning. The trip down the bay is very pleasant and enjoyable, but the early hour at which one is obliged to disembark is far from agreeable; or one may take the train at Union Station and changing to the Delaware Railroad may, by a circuitous route, reach Crisfield in five or six hours. It is, however, a much more pleasant trip to go by steamboat. At the time of our arrival the boatmen were beginning to go out in their boats to their daily work. These boats going out in large numbers present a very beautiful and interesting sight and with their sails spread resemble flocks of huge birds skimming over the surface of the water. They come back laden with crabs, or oysters, or other sea game. Another very peculiar and interesting industry is that of raising terrapins for the market. One terrapin pond which we visited was filled with thousands of diamond back and other varieties of terrapin. These terrapins are exported to New York and other large cities and are sold at high prices to the famous hotels and restaurants of these centres. Diamond back terrapins seven inches in length sell for $3 apiece, whilst those eight inches in length bring $100 a dozen. They are caught by huntsmen, who sell them to the owner of the pond, who keeps them until they are fit for the market. There is an obsolete law which prohibits feeding slaves on diamond back terrapin oftener than twice a day.

The University of Maryland is well represented at Crisfield by its medical graduates, Drs. C. E. Collins, W. H. Colbourne, Wm. F. Hall, G. T. Simonson and J. F. Somers, who are all established in extensive practice, and by Dr. R. R. Norris, lately of Baltimore, who has very recently removed to Crisfield.

RANDOLPH WINSLOW.

ITEMS.

Doctor Nathan Winslow, class of 1901, of Baltimore, has left for Richmond, where he will visit points of interest.

Doctor William Emrich, class of 1902, of Baltimore, has returned to his native city after a residence of a year in the interior of Brazil, where he has been engaged in the practice of his profession. In three months' time he expects to return to Brazil.

Doctor Edson W. Glidden, Jr., class of 1907, of Savannah, Ga., and formerly a resident physician in the University Hospital, has been spending a few days in Baltimore visiting the University Hospital.

Doctor St. Clair Spruill has been elected assistant surgeon to St. Agnes' Hospital, Baltimore, and Doctor John T. O'Mara has been appointed his assistant.

Doctor John Wilson MacConnell, class of 1907, of North Carolina, recently visited the University Hospital. Amongst other visitors may be mentioned Dr. Washington Claude, class of 1875, of Annapolis, Md., and Rufus Cecil Franklin, class of 1907, of Georgia.

Doctor and Mrs. William Hewson Baltzel, of Boston, are spending a few days at the Hotel Belvedere, Baltimore.

Doctor Harry Young Righton, class of 1907, of Savannah, Ga., is visiting friends in Baltimore. After the completion of his course at the University of Maryland he was resident physician at St. Joseph's Hospital, Baltimore, for a year.

Dr. T. A. Ashby, of the Faculty of Physic, has been nominated by the Democratic party as one of its candidates for the Legislature, from the Third District of Baltimore city. The nomination came to Dr. Ashby unsolicited, and he was induced to accept it against his personal interests as a duty which he believed he owed the medical profession and people of the State.

Dr. Ashby is the only physician in the city delegation and will be in a position to render a most efficient service in trying to procure the passage of laws which will improve the health, comfort and educational interests of our people.

If elected he will go to Annapolis with the sole purpose of trying to use his influence and ability for the general uplift of all classes of legislation. His long training as a practitioner of medicine, teacher and editor, and his large acquaintance with physicians throughout the State

and with public officials will be of great service to him as a member of the Legislature.

After having a hard fight against death Dr. A. L. Wilkinson, Cole avenue and Belair road, Raspeburg, is now able to attend to his professional duties again.

Doctor and Mrs. Henry B. Thomas have closed their house at Catonsville and are spending July and August at Blue Ridge Summit, Pa.

Doctor J. Clement Clark, class of 1861, of Sykesville, Md., is spending the summer at Ocean City, Md.

Doctor and Mrs. Frank Chisolm, of Washington, formerly of Baltimore, left recently for the Berkshire Hills, where they will spend their summer vacation.

Doctor H. W. Wickes, passed assistant surgeon, United States Public Health and Marine Hospital Service, has been granted one month's leave of absence from August 1, 1909.

Dr. Eugene H. Mullan, passed assistant surgeon of the same service, has been granted two days' leave of absence from July 12, 1909.

Doctor and Mrs. James M. Craighill have left for Canada, where they will spend a month at the various places of interest.

Doctor Martin J. Hanna, a graduate of Sewanee University, but formerly a member of the class of 1908, was married recently to Miss Sarah S. Rust, at the home of the bride, 113 North Fremont avenue. Upon their return from a honeymoon, spent in the North, Dr. and Mrs. Hanna will reside at 237 North Fulton avenue, Baltimore.

Doctor John S. Fulton has sailed for Europe where he will spend the remainder of the summer traveling.

Doctor T. C. Gilchrist has sailed for Europe where he will visit points of interest.

Dr. and Mrs. Irving Miller are summering in Maine.

Dr. Samuel Theobald has returned to his home from a visit to New London, Conn.

The Baltimore County Medical Society met at Springfield Hospital, Sykesville, July 15, 1909. After luncheon Dr. J. Clement Clark, class

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of 1881, superintendent of the hospital, showed the visitors over the institution in company with the city grand jury. The members of the society expressed themselves pleased with the management of the hospital and its methods. The society was addressed by Dr. Clark. Among those present were: Drs. John Winslow, M. G. Porter, F. J. Kirby, Henry A. Naylor, H. Louis Naylor, Josiah S. Bowen, A. D. McConachie, J. F. H. Gorsuch, Frank J. Keating.

Doctor W. E. Wiegand and family have gone to Asbury Park, New Jersey, for the summer.

Dr. and Mrs. G. W. Dobbin have closed their town house and taken a house on Charles street, extended, for the summer.

Dr. R. B. Warfield has left for a six weeks' stay in Europe.

Dr. C. E. McElfresh and family have left for Fairmont, West Virginia, where they expect to stay some time.

Dr. Hiram Woods has returned from New London, Conn.

Dr. and Mrs. Frank Crouch are in the White Mountains, where they expect to remain several weeks.

Dr. Frank Martin will spend the late summer in Europe.

Dr. and Mrs. J. William Funk are spending the summer at Ocean City, Md.

Dr. Silas Baldwin has almost recovered from the recent driving accident in Druid Hill Park.

Dr. Allan Walker, class of 1886, of Washington, D. C., recently paid the hospital a visit where he renewed old acquaintances.

Professor Charles Wellman Mitchell, one of the regents and formerly dean of the medical department of the University of Maryland, recently appointed to the vacancy in the chair of medicine caused by the recent resignation of Professor Samuel C. Chew, is a native of Baltimore and for some years has held the chairs of Diseases of Children, Therapeutics and Clinical Medicine in the Medical Faculty, the latter two of which he now relinquishes. He received the degree of Bachelor of Arts at Princeton in 1879, and afterwards the degree of Master of Arts.

Doctor Arthur M. Shipley, associate professor of surgery, has been made professor of therapeutics and surgical pathology and a member of the Board of Regents. Dr. Shipley, who is from Anne Arundel county, was honor man of the class of 1902. After graduation he was appointed assistant resident surgeon to the University Hospital, a position he held two years, then was promoted to the superintendency of the University Hospital where he remained until June, 1908, when he entered upon the practice of surgery in the city of Baltimore.

Doctor A. Duvall Atkinson has resigned his clinical professorship of medicine. He and his wife will spend the summer touring Europe.

Under the caption of leading men of Maryland the Baltimore Star presenting his portrait has this to say concerning Doctor Joshua W. Hering, class of 1855:

"Dr. Joshua W. Hering, who in December will end his third term as State comptroller, and who will be renominated for a fourth term at the coming Democratic State Convention on August 11, 1909, is probably the most popular man today in the Democratic party in Maryland. Besides being a physician and State comptroller, Dr. Hering is a banker. His home is at Westminster. Before his election as State comptroller, in 1899, he had served two years in the State Senate. In point of age and public service, Dr. Hering may be called the grand old man of the Democratic party. He has passed his seventieth milestone."

Doctor Elijah Miller Reid, class of 1864, late professor of diseases of the nervous system and of the throat and chest, Baltimore University School of Medicine, is a prominent practitioner of the city of Baltimore. He is a native of Ohio, born near Lancaster, Fairfield County, November 15, 1844, and is a son of Thomas N. and Keturah (Miller) Reid. His elementary education was acquired in the schools of Baltimore. At sixteen years of age he entered the medical department of the University of Maryland from whence he was graduated in 1864. For a few months following his graduation he practiced medicine, then having passed the examination of the Army Medical Board, he entered the United States Army as an acting assistant surgeon, and was assigned to Columbia College Hospital, and later was stationed at Armory Square and Lincoln Hospital, Washington, D. C.

After his service in the army, Dr. Reid established himself on the Reisterstown road, in Baltimore county. In 1869 he returned to the city of Baltimore, where he has since resided. In 1888 he accepted the chair of physiology, hygiene and diseases of the throat and chest in Balitmore University School of Medicine, in which chair he remained until 1892, when he was transferred to the chair of diseases of the nervous system and the throat and chest. In 1906 he resigned his professorship. In 1887-88 he was chairman of the section on medical jurisprudence of the American Medical Association. Doctor Reid married November 9, 1887, Mary A. Allen, daughter of John Allen, of Baltimore. Four children were begotten by this union, all of whom are now dead.

Doctor Wirt Adams Duvall, of Baltimore, class of 1888, was born in Anne Arundel county, Maryland, October 21, 1863. His elementary education was acquired in the public schools, and in St. John's College, department of Arts and Sciences, University of Maryland. In 1895 he received from his alma mater his M. A. degree. After leaving college he matriculated in the medical department of the University of Maryland where he received his medical degree with the class of 1888. From 1890-92 he served as city vaccine physician, assistant demonstrator of anatomy, University of Maryland, 1889-90; demonstrator of osteology, Baltimore Medical College, 1893-95; demonstrator of osteology, University of Maryland, 1897-98.

General Thomas Andrew McParlin, United States Army, class of 1847, was born at Annapolis, July 10, 1825, and died in the house in which he was born, January 28, 1897. His parents were William McParlin and Cassandra Hillary Beall

Woodward. His father was an officer in the war of 1812. He received his literary education at St. John's College, Annapolis, now department of arts and sciences of the University of Maryland, graduating with the degree of B. A. in 1844. He graduated from the University of Maryland medical department in 1847, and immediately entered the medical corps of the United States Army. He served in the Mexican War in 1848, in the Seminole War in 1856-57, and through the Civil War. He was medical director of General Grant's Army in the Richmond campaign. In 1866, at the recommendation of General Phil. Sheridan, he was brevetted brigadier general for meritorious service. In 1858 Dr. McParlin married Miss Alida Yates Leavenworth Roca, by whom he had four children, Alida, now wife of Senor Don Manuel Elguera, of Lima, Peru; Agnes Cassandra; Harriet Clare, wife of Dr. Michael J. Sullivan, of Englewood, N. J., and Eleanor Beall, wife of Dr. Isaac H. E. Davis, of Baltimore, Md.

Doctor Henry Merryman Wilson, a general practitioner of medicine in Baltimore for more than fifty-seven years, ex-president of the Medical and Chirurgical Faculty and in many other ways prominently identified with the professional life of the city and one of our distinguished alumni, was born in Baltimore, February 2, 1829, son of Luther Wilson and Achsah Merryman, his wife. His early education was acquired under private instruction and his collegiate at Dickinson College, Carlisle, Pa., where in 1848 he received the degree of B. A. He was educated in medicine in the department of medicine, University of Maryland, graduating from there in 1851. Since that time he has been a prominent figure in the professional circles in the city of Baltimore. He became a member of the Medical and Chirurgical Faculty in 1853, of which body he was secretary from 1859 to 1873, vice-president in 1873-74, and president in 1874-75. In 1886-87 he was president of the Alumni Association (Medical) of the University of Maryland. He is a trustee of Dickinson College, and of the Woman's College, Baltimore. On October 7, 1851, Dr. Wilson married Eliza Kelso Hillingsworth. Their children are: John Kelso, Anna Ward, Luther Barton, Maude Hollingsworth and Henry Merryman Wilson, Jr.

Doctor August Horn, class of 1888, formerly associate professor of dermatology and diseases of children in the Baltimore University Medical College, was born in Baltimore on the 30th of June, 1868. His early education was obtained at Milton Academy and Marston's University School for Boys and his Collegiate in the Academic Department of the John Hopkins University. He was educated for the profession of medicine at the University of Maryland, graduating with the class of 1888. Since graduating Dr. Horn has been engaged in the practice of medicine in Baltimore and at various times has held the positions of city vaccine physician, police surgeon and physician to the Augsburg Home for the Aged. In 1891 he was elected a member of the Medical and Chirurgical Faculty.

Thomas Melville Talbott, class of 1870, a native of Falls Church, Fairfax county, Va., ex-president of the Fairfax County Medical Society, and a general practitioner of medicine of more than thirty-five years, was born near White's Ferry, in Montgomery county, Va., on the 17th of October, 1848. He is a son of Benson and Maria Hyde Talbott. He was educated in the public schools of Montgomery county. In 1868 he entered the medical department of the University of Maryland, whence he graduated in 1870. During his senior semestre he was a resident student in the University Hospital. Dr. Talbott began his professional career in Baltimore, but soon afterwards moved to Georgetown, where he only practiced a few months, removing from thence to Falls Church, Va., where he is still, located. He is a member of the Virginia State Medical Society.

In 1876 he married Miss Ella Febrey, who died, leaving one son, Dr. Edward M. Talbott, assistant surgeon United States Army. In 1892 Dr. Talbott married Miss Kathleen Nourse, by whom he has three children, Philip M., Harold W. and Kathleen Talbott.

Doctor Joseph Smith Horner, class of 1883, of Hot Springs, Ark., who has been a resident physician and surgeon of that place for the past twenty years, is a native of Missouri, and was born in Hornersville, September 10, 1858. He is a son of Dr. William Hicks and Margaret Elizabeth (Smith) Horner. His early education was received in public schools and his higher education in Arcadia College, at Arcadia, Mo., Colorado College, at Colorado Springs, and the University of Illinois, where he was a student in 1876-1877. At the beginning of the session of 1881 he matricu-

lated in the medical department of the University of Maryland and graduated with the degree of Doctor of Medicine in 1883. During his senior year Dr. Horner served as an interne at the University Hospital. After entering general practice he attended for a time as a graduate student the St. Louis Polyclinic. In July, 1888, he removed from Bloomfield, Mo., where he had been practicing for five years and located in Hot Springs, where he has since been engaged in the practice of medicine. He is a member of various professional organizations, among them being the Hot Springs-Garland County Medical Society, Arkansas State Medical Society, and the American Medical Association. He is a Mason, Knights Templar, a member of the Benevolent and Protective Order of Elks, and of the Presbyterian Church.

On June 2, 1884, Dr. Horner married Miss Alice Bell Buck, by whom he has five children, Margaret Elizabeth, Carl Horner, deceased; Helen Edith, Frances and William Lawrence Horner.

Doctor William Christian Sandrock, class of 1878, of Baltimore, former vice-president of the Adams County Medical Society, and former president of the New Oxford School Board, both Pennsylvania Institutions, was born in Baltimore, October 2, 1854. Having received his literary education in the public schools and Knapp's Institute, he entered Maryland College of Pharmacy, now the department of Pharmacy of the University of Maryland, whence he was graduated with the degree of Ph.G. in 1875. He then matriculated in the medical department of the University of Maryland and graduated from there with the degree of Doctor of Medicine in 1878. Doctor Sandrock immediately after graduation entered upon the practice of medicine in Adams county, Pennsylvania.

In 1889 he returned to Baltimore and has since practiced in this city. In 1890 he became a member of the Medical and Chirurgical Faculty.

Dr. J. P. Young, of Richburg, S. C., writes, "THE BULLETIN is always a welcome visitor to my home, and I wish for it a long life and increasing usefulness.

In your notices of marriage you might add that of Dr. John P. Young, of Richburg, S. C., to Miss Constance Witherspoon, of Lancaster, S. C., on June 23rd, 1909."

THE BULLETIN congratulates Dr. Young and wishes him much happiness and success in life.

Through an unfortunate oversight on the part of the printer, the closing sentences of Prof. Chew's paper published in the July 15th number of THE BULLETIN were omitted. They are herewith presented:

There is however one special case, and a very serious one, too, with which physicians are not infrequently confronted: it is the knowledge of the existence of specific disease in one who is or has been recently under the physician's care, and who is contemplating marriage within the time in which it would be improper. In such a case, if the warning counsel of the physician with a pure statement of what may be the consequences should be disregarded, so that misery and wretchedness, corruption of body and ruin of mind may be impending over an innocent person, the parents or other friends of the one endangered should be informed, for otherwise the physician could be justly regarded as an accessory before the fact with guilty knowledge. I have endeavored to give some illustrations of what should be our ethical course of action in varying cases, and I may say in conclusion that the best ethical guide in all cases and under any circumstances may be found in these words from the Divinist lips: "All things whatsoever ye would that men should do to you, do ye even so to them."

DEATHS.

Doctor William H. Whitehead, class of 1870, of Rocky Mount, N. C., died in Raleigh, June 25, 1909, of paresis. In his death the State of North Carolina has lost one of her best citizens and the medical profession an honored member. Doctor Whitehead has held many places of honor and trust. He was at the time of his death, an honorary fellow of the North Carolina State Medical Society. From 1890 to 1896 he was a member and president of the North Carolina State Board of Medical Examiners; from 1901 to 1905 a member of the State Board of Health; in 1885 vice-president of the Medical Society of the State of North Carolina. He was also a member of the Board of Directors of the Central Hospital

for the Insane at Raleigh. Since 1885, when he passed the examination of licenseur he has been actively engaged in the practice of his profession in the State of North Carolina. He spent his early professional career in Baltimore. In 1892 he located at Rocky Mount, where for years he was division surgeon and adjuster of damages for the Atlantic Coast Line Railway. He enjoyed a large and lucrative practice, was greatly loved by all with whom he came in contact and stood high in the esteem of his fellows. In chronicling the death of Dr. Whitehead, the Old Dominion Journal of Medicine and Surgery, July, 1909, gave voice to the following sentiments:

"In the death of Doctor William Henry Whitehead, of Rocky Mount, N. C., on Thursday, July 1st, 1909, the medical profession of the South has suffered a great loss. Unusually strong both mentally and physically, he was acknowledged a leader among men. A useful citizen, he was ever ready to give his aid where worth was recognized, and many a successful man owes his position to the helping hand extended to him while struggling for an education. Whole-souled, of a bright and sunny disposition, he carried cheer into many a home darkened by the shadow of suffering. Distinguished among his confreres of the South, he was a wise, conservative and skillful physician.

"Doctor Whitehead was born in Edgecomb county, North Carolina, in 1850. His parents belonging to the oldest and best families of that community, gentle breeding was his by inheritance, and he was taught early that high standard of morals and rectitude to which he so rigidly adhered during his entire life. An intense lover of nature, he was as a boy able to study and enjoy it to the utmost in the woods and by the gently flowing streams of his eastern home. Actively engaged in the cultivation of his father's farm, he gained a knowledge and experience in agricultural life that served many useful purposes in his after life. Here he learned to appreciate the dignity and nobility of human labor, and also the proper respect and sympathy for the laboring man. The care of animals intensified the spirit of innate kindliness and pity, not only for the helpless dumb beast, but in after years for his fellow man. Very much of his success in life can be attributed to the lessons in economy and industry learned during these early days on the farm.

"At the age of nineteen he commenced the study of medicine, and graduated from the medical department of the University of Maryland, in the class of 1870. He practiced in Battleboro and gained an enviable reputation as a practitioner and surgeon. In 1891 he accepted the position of chief surgeon to the Atlantic Coast Line Railroad Hospital in Rocky Mount, where he resided up to his death. He was local surgeon to the Southern Railway, and consulting surgeon to the Pittman Sanitarium in Tarboro, North Carolina. His death occurred at Raleigh, where he had been under treatment for some time.

"We of Virginia envy our sister State in thus producing so splendid a type of the "True Physician," and share with her the sorrow of his loss."

John Woolf Burton, M. D., University of Maryland, Baltimore, 1865; Washington University, Baltimore, 1872; for many years a member of the Medical Society of the State of North Carolina; committed suicide at his home in High Point, June 30, by hanging himself in his stable, while mentally irresponsible from ill health and despondency, aged 65.

Richard Benbury Creecy Lamb, M. D., University of Maryland, Baltimore, 1904; of Yslita, Texas; died in Providence Hospital, El Paso, Texas, June 22, from typhoid fever, aged 26.

MARRIAGES.

Doctor J. P. Young, a prominent physician of Richburg, S. C., class of 1894, was married to Miss Constance Whitherspoon, of Lancaster, S. C., June 23, 1909. The wedding took place at the home of the bride's brother, Mr. Marion Witherspoon, in Lancaster. Soon after the ceremony the bride and groom left for an extended bridal tour in the North. Upon their return they will make their future home in Richburg.

Doctor John W. MacConnell, class of 1907, of Davidson, N. C., formerly resident physician in the Presbyterian Eye, Ear, Nose and Throat Hospital, of Baltimroe, was married Wednesday, July 28, 1909, to Miss Agnes H. Doyle, daughter of Mr. and Mrs. A. Courtney Doyle, by Reverend D. D. Douglas, pastor of Maryland Avenue Presbyterian Church, at the residence of the bride's parents, Chestnut avenue and Eleventh street, Walbrook, Baltimore, Md. After the ceremony Dr. and Mrs. MacConnell left for a trip North. They will make their home at Davidson, N. C.

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THE PROFESSORS OF SURGERY IN THE UNIVERSITY OF MARYLAND.

By Randolph Winslow, M. D.

No. 1. John Beale Davidge, A. M., M. D.

In the first hundred years of the existence of the University of Maryland there have been seven professors of surgery—John B. Davidge, William Gibson, Granville Sharp Pattison, Nathan R. Smith, Christopher Johnston, Louis McLane Tiffany and Randolph Winslow.

I desire to present short sketches of my predecessors in the surgical chair in order that our students and graduates may have some knowledge of those who have filled this chair, from the beginning of the school to the present time. These sketches will contain nothing original by me, but are merely condensed histories taken from "The History of the University of Maryland," written by Prof. E. F. Cordell. These men have all been distinguished in their day and generation and have rendered important and valuable services in the cause of humanity and of science. The first of these is

John B. Davidge.

The charter for the founding of the College of Medicine of Maryland was granted by the Legislature on December 18, 1807. In the 16th section of this charter it is enacted that John B. Davidge, M. D., and James Cocke, M. D., shall be joint professors of anatomy, surgery and physiology. In the division of this work Dr. Davidge delivered the lectures on surgery until 1812, when Dr. William Gibson was elected professor of surgery, and held the chair until 1819. Dr. Davidge during that period conducted the courses of instruction in anatomy. From 1819 to 1821 Dr. Davidge discharged the duties of both the surgical and anatomical chairs, when Granville Sharpe Pattison was elected to the chair of surgery. In 1826 he again took up the duties of the chair of surgery, upon the resignation of Professor Pattison. He relinquished the chair in 1827, when Dr. Nathan R. Smith was elected professor of surgery.

Dr. John B. Davidge was born in Annapolis in 1768. His father died whilst he was still young, and he became reduced in circumstances, but with some assistance he was enabled to enter St. John's College and obtained therefrom the degree of A. M. in 1789. He began the study of medicine with the Drs. Murray, of Annapolis, and later entered the University of Edinburgh, but took his degree of Doctor of Medicine at Glasgow University, Scotland, on the 22nd of April, 1793. He married a Scotch lady and practiced a short time in Birmingham, England, but soon returned to Maryland, and settled in Baltimore in August of 1796. A severe epidemic of yellow fever prevailed in the city in 1797, and Dr. Davidge formed very definite opinions in regard to the origin of this disease, and came near being the discoverer of the causation of the disease by means of the bite of infected mosquitoes, which discovery has since made the names of Walter Reed and James Carroll and Jesse Lazear famous. Dr. Davidge published his views on yellow fever in 1798, in a volume which attracted considerable notice. In 1802 he began to give private courses of instruction to medical students, which were continued until 1807, when, being associated with Drs. Cooke and Shaw, his private school became the College of Medicine of Maryland, which later became the University of Maryland. Dr. Davidge thus became the founder of the University of Maryland and was known as the Father of the University. He was twice married, the first time as stated to a Scotch lady, Miss William Stuart, and after her death, to Mrs. Rebecca Troup Polk, of Harford county, Maryland, who survived him with four children, a son by his first wife, and three daughters by his second. Professor Davidge is said to have been a short man, with blue eyes and a ruddy complexion and homely features. He was neat in his dress and dignified in his manner, and acquired a large practice in the City

of Baltimore. He was a person of great influence in the medical profession of the day, and though of somewhat irritable disposition, he was much regarded by his acquaintances, and held in high esteem by his students. He was an excellent lecturer, and a diligent student, but was an obscure writer, and expressed himself in pompous and confusing language. Surgery was at this time more or less in its infancy, and the surgeons were also practitioners of medicine. He performed, however, several important operations, such as total extirpation of the Parotid Gland, ligation of the Gluteal Artery for aneurism, and ligation of the Carotid Artery for fungus of the Antrum. He also invented a new method of amputation, which he called the American. He wrote a treatise on yellow fever in 1798, a treatise on amputation in 1818, and edited Bancroft on fevers in 1821, and was besides a frequent contributor to the medical and scientific journals of his day. He died at his residence on Lexington street, on the 23rd of August, 1829, the cause of death being a malignant growth of the face, originating in the Antrum. The disease was first noticed in June, 1829, and grew rapidly and was accompanied with great suffering. At this late period in the history of the University a memorial has been established to him by renaming the recently acquired Calvary Church, which is now used as a library and Y. M. C. A. building, Davidge Hall.

LEUCORRHOEA.

By Hugh W. Brent, M. D.,

Instructor in Gynecology, University of Maryland.

The importance of leucorrhoea as a symptom of pelvic diseases finds no place in the mind of the average woman—to her "whites are whites," and that settles the question unless the co-existent disease be of such character as to attract her attention through the medium of pain, the discomfort of "profuseness" or the sometime result—excoriation of the vulva and adjacent skin surfaces.

Woman unenlightened, regards the symptom as a disease and through ignorance fails to properly interpret the subtle warning in an intelligent way. And why should she not be ignorant?—as ignorant as we may be of astrology or Hindu magic. You see it doesn't happen to be in her line to know the "why" and "wherefore." She looks to the physician to ferret out the seat of evil and "properly interpret"—you see it happens to be *our* business to understand these things, to look beyond "whites are whites." To blithely prescribe hot douches for "that vaginal discharge" *may be* a procedure beyond reproach or it may be *dangerous, irrational* and *useless,* a trio certainly deserving consideration if one is to practice Medicine not medicine.

The causes of leucorrhoea are myriad and until we have solved its *raison d'etre* with at least reasonable certainty we are not justified in attempting its correction. True the cause is often difficult of discovery, but in the majority of cases painstaking examination will reveal the underlying pathologic process, and we will be enabled to establish a rational line of treatment. It may be well to first briefly consider the normal physiologic secretions of the genitalia derived from the glandular systems of the vulva, Bartholin's glands, Skene's glands, the cervix and corpus uteri. The vagina closely approaches the skin in structure and is practically non-secretory though a few isolated glands are occasionally found in this locality. Its surface is bathed in the uterine and cervical secretions, thickened with desquamated vaginal cells and rendered acid through the normal presence of non-pathogenic acid producing organisms, notably the Bacillus Vaginalis of Döederlein. In health is varies considerably in amount and is much increased during pregnancy when the cervical glands are especially active and the cycle of cellular life in the vaginal mucosa, hastened through the impetus of increased nutrition, increases the amount of cellular debris. Especially during the latter part of pregnancy one may expect to encounter a rather profuse vaginal discharge, which is in no way pathologic.

The vulva is generously supplied with sweat and sebaceous glands, their activity varying with the individual and the seasons. The normal secretions of the vulva may, however, in uncleanly women become through accumulation and decomposition a source of irritation. Bartholin's vulvovaginal glands pour out on either side of vaginal outlet, through ducts opening in front of the hymen a thin, transparent mucoid secretion designed as a lubricant during coition. When not influenced psychically they are almost quiescent—and very naturally so. Their function has to

do with sexual activity and it is only under the influence of sexual excitement that they become functionally active. Secretion at this time may be extremely profuse, but should be ever borne in mind as entirely normal, the amount varying with the intensity of the individual's desire.

Skene's glands, situated on either side of the urethra, empty their secretion on the inner aspect of the labial urethrae, their function is the lubrication of the urethral orifice and their small size renders them insignificant (even when infected) as a source of discharge.

The secretions of the clitoris are so slight in health as to escape notice, an adherent prepuce or uncleanliness may however give rise to more or less trouble of an irritative character.

We come now to the two most important glandular systems associated with the production of leucorrhoea—those of the corpus uteri and cervix. Their secretions differ very essentially and it is often possible to determine the source of discharge by the physical characteristics of the secretions.

The cervical glands tortuous and deeply situated evolve a clear viscid alkaline mucous—the uterine glands much less complicated in structure, secrete a thin, serous alkaline fluid, destined to moisten the uterine mucosa, but having as one of its principal functions the prevention of clot formation in the menstrual blood.

Before considering the pathology of leucorrhoea I wish to mention the normal premenstrual increase in glandular activity, under the stimulation of premenstrual pelvic congestion. This period of hypersecretion, if I may term it such, is directly responsible for the widespread belief among the laity that menstrual blood is productive of gonorrhoeal infection, i. e., the menstrual blood of a healthy woman. This of course is absurd, but it is well to bear in mind that women are especially likely to transfer the disease at this time, for the following reason: Hypersecretion tends to "bring out" organisms lying quiescent in the depths of a gland and the woman may thus become actively infectious, though exhibiting a comparatively slight tendency toward transference of the disease during the inter-menstrual period.

THE PATHOLOGY OF LEUCORRHOEA.

General Systemic Disease.
Pelvic Congestion.
Uterine Malposition.
Foreign Bodies.
Cancer of the Cervix and Corpus Uteri.
Genital Tuberculosis.
Puerperal Infections and the Traumata of Labor.
Gonorrhoea.

The influence of extra-genital diseases in the causation of leucorrhoea is indefinite and infrequent—the popular assumption that "whites" are the result of "weakness" (whatever that may be) is merely a confession of ignorance. With the exception of the possible influence of chronic constipation and such lesions of the heart, lungs, liver or kidneys that may cause stasis of the pelvic blood supply through circulatory obstruction, we may practically disregard extra-pelvic affections as etiologic factors.

Pelvic congestion from whatever cause is a prolific source of "vaginal discharge." As the gross lesions of the pelvis causing congestion will be considered later it may be well to discuss here an element of psychic origin that plays no small part in this relation. Sexual excitement without gratification is entirely unnatural from the view point of the animal organism. The natural law of sexual relation demands that libido-sexualis, with its attendant pelvic congestion and nervous excitation be followed by completion of the sexio-erotic cycle through natural coitus with orgasm. If for any reason, physical, social, moral, or marital, there is continual violation of this basic principle we may expect to find in the woman the usual concomitants of chronic pelvic and ovarian congestion—pain, reflex nervous phenomena and *leucorrhoea*, a leuchorrhoea entirely unrelievable by local applications "to the womb" or the famous "hot douche."

Uterine malposition, especially retro-displacement and prolapsus, are often accompanied by venous stasis in the uterus, and its almost inevitable sequence—endometrial hypersecretion.

Foreign bodies whether pessaries or the instruments of masturbation may cause vaginitis or ulceration of such degree as to give rise to profuse "vaginal discharge."

Genital tuberculosis usually affects not only the uterus but the adnexa and pelvic peritoneum as well, unless the bacillus can be demonstrated in the discharge or the characteristic lesions recognized microscopically in uterine scrapings, a positive diagnosis can rarely be made. Of course where salpingitis is coexistent an abdominal section reveals the true state of affairs.

In malignant disease of the uterus the first discharge noted is clear and watery, the product of congestion and the new growth. This watery discharge associated with menorrhagia or metrorrhagia occurring about the menapause should at once excite suspicion of cancer and is an indication for immediate and searching investigation. We must ever bear in mind in this connection that cancer, though commonly considered as occurring rather late in life, is sometimes met with in young women. As the disease progresses and necrosis with ulceration occurs the discharge becomes thick, corrosive and fetid, parametrial invasion has taken place and the golden opportunity for radical extirpation of the growth is a thing of the past. In the pathologic causation of leucorrhoea we may consider the traumata and infections of labor and the puerperium as playing a role secondary only to gonorrhoeal invasion of the genital tract.

Cervical laceration with infection is a common cause of "discharge" and may be the single lesion in a profuse leucorrhoea. Even in those cases in which no discoverable laceration exists, minor tears in the mucosa and musculature of the cervix within the canal, may become infected during the puerperium, the only clinical evidence of their existence being the characteristic mucopurulent discharge and associated erosion of the porti vaginalis. Inflammation of the endometrium is not as common as one might think and when it does occur is not likely to be of long duration. We do indeed often encounter a discharge in child-bearing women, the product of the endometrium, but this is in most cases a hypersecretion brought about by congestion dependent upon subinvolution or displacement, or both.

Acute puerperal infections may or may not be accompanied by leucorrhoea, though as the disease advances it always makes its appearance and may be very profuse. The etiology is found in endocervicitis, endometritis, metritis, salpingitis and pelvic peritonitis; either of these is sufficient or the entire group may be coexistent.

The leucorrhoea accompanying a puerperal salpingitis differs little from that seen in tubal inflammation of gonorrhoeal origin with the exception of the possible demonstration of the gonococcus. The discharge in salpingitis is usually directly dependent upon the chronic pelvic congestion associated with pelvic inflammatory disease. Of course in some cases there is an associated endometritis.

That occasionally drainage does occur through the uterine end of the tube is not to be denied, but it is very rare. Inflammatory thickening of the mucosa in this the narrowest portion of the canal, effectually prevents the extrusion of the products of inflammation into the uterine cavity.

In hydrosalpinx which is usually of inflammatory origin we occasionally encounter the so-called "Hydrops Tubae Profluens," in which the tube periodically empties itself by way of the uterus. The condition is comparatively rare and is probably due to causes other than pre-existent pyosalpingitis.

The point of importance in tubal disease is, that it is folly to treat minor conditions in the cervix and uterus without bimanual pelvic examination. If one be guilty of this indiscretion he may expect often to miss the true source of the leucorrhoea—"higher up."

Gonorrhoea is by far the most important etiologic factor in genital discharge, not only because of its frequency, but through the extremely serious consequences resulting from failure to recognize this disease. Gonorrhoea in the female is difficult to combat when one fully realizes its power for harm and is thoroughly competent and conscientious in its treatment. The existence of such a malady is sufficient in itself to demand of every physician worthy of the name a searching investigation when he is called upon to treat "that little discharge." Infection of the entire genital mucosa and glandular system is not uncommon in acute gonorrhoea, but as the disease becomes chronic there is a tendency toward localization in certain areas, noticeably Bartholin's glands the cervical and corporeal endometrium and the fallopian tubes. In these structures it may remain semi-latent for years—a source of discomfort and leucorrhoea to the woman and a potent factor in the dissemination of the disease through prostitution. Clinically, the discharge in gonorrhoea is characteristic, viewed by the experienced eye. But before making a diagnosis it is preferable to demonstrate the gonococcus—the best "smears" being obtainable from the urethra and Bartholin's glands.

Leucorrhoea is a vast subject and the author appreciates the woeful deficiency of such a brief paper. If, however, he has made plain that "vaginal discharge" is always due to some specific

lesion usually discoverable through painstaking examination and that only through treatment of *the cause* can one hope to be successful in its cure—he will feel that the time consumed in the preparation of this article has been well employed.

2124 Maryland Avenue.

A CASE OF FRACTURE OF THE CLAVICLE WITH PECULIAR SYMPTOMS.

By Everette Iseman, '09,

Senior Medical Student.

Fracture of the clavicle is the most common of all fractures, and the symptoms are usually characteristic, but in some exceptional cases, the clavicle may be fractured without presenting the usual symptoms. A case of this character came recently under our observation.

Case—G. K., white, age 16 years, a sailor by occupation, was admitted to the University Hospital on January 19, 1909. Four days previously whilst going down a ladder on shipboard, he slipped and fell about five or six feet, striking his head first and then his left shoulder. He was able to get up but found that his left shoulder pained him a little. This was about 8 o'clock in the evening, about 4 o'clock in the morning he awoke with a great deal of pain in the shoulder and the ship's doctor was called and examined him, and pronounced the injury a bruise. The arm was put up in a bandage which gave him relief from pain. Two days later the bandage was removed and the boy could move his arm in any direction without pain, and could also put his hand on his head, and swing his arm backwards and forwards without discomfort. Upon reaching Annapolis, he was examined by one of the surgeons of the Naval Academy, who also did not think that there was a fracture, but recommended sending him to Baltimore to a hospital, as the boy was unable to work. When he was admitted to the University Hospital, a lump was found in the middle of the clavicle but the boy could move the arm in any direction without pain, he could also put the hand of the injured side upon the top of his head without the least difficulty, hence it was thought by the physician who admitted him that the injury was a bruise and not a fracture. The next day when Professor Winslow made his rounds of the wards, the case was called to his attention, and he found, as has been stated, a lump over the middle of the clavicle, which was not tender upon pressure but was discolored from contusion. Upon manipulating the parts it was possible to get distinct motion and crepitus at this point, and it was evident that a fracture was present at the middle third of the collar bone. The boy was perfectly able to place his hand on the top of his head without inconvenience, and could readily move his arm in any direction. He was placed upon the table with a pillow between his shoulders causing the shoulders to be thrown backwards and the left arm was abducted and rotated outward. Whilst in this position a plaster cast was applied to his chest and arm, fixing the arm in this position, with firm pressure upon the point of fracture. The cast was comfortable to the patient and was not removed until February 25, when firm union was found to have taken place, with but slight deformity. One of the characteristic features of a broken collar bone is the absolute inability of the patient to execute the ordinary movements of the arm or to put the hand upon the top of the head. Deformity is usually present at the seat of fracture, as was the case in this instance; usually there is no displacement or deformity in a case of fracture of the clavicle, when the break is situated about one inch from the outer extremity of the bone. Running from the coracoid process to the under surface of the clavicle are two ligaments known as the conoid and the trapezoid ligaments. When a fracture of the collar bone occurs about one inch from its outer extremity, the line of fracture lies between the conoid and trapezoid ligaments and there is no displacement of the fragments. In all other forms of fracture of this bone there is both displacement and deformity. Sometimes with this form of fracture the person may be able to use the arm though usually with difficulty.

Another case occurring in the practice of Professor Winslow, illustrating these points, was that of a colored woman, who having an altercation with her husband, was thrown by him against the door, injuring her shoulder. When seen the woman was ironing clothes, though with pain, and she could also place her hand on her head. There was absolutely no displacement of the bones and no deformity, but when the shoulder was carefully examined distinct crepitus could be felt at the outer extremity of the clavicle, showing that a fracture had taken place. I have reported these

cases as they are unusual, and serve to show that variations occur, and hence the necessity of making careful examinations in all cases of fracture about the neck and shoulder as well as in all other regions of the body.

ABSTRACTS.

IS PUBIOTOMY A JUSTIFIABLE OPERATION?

J. Whitridge Williams, class of 1888, Johns Hopkins University. (American Journal of Obstetrics.)

"Thus, assuming that the figures given above are approximately correct and that two series of 1,000 cases of moderately contracted pelves were treated by pubiotomy and the induction of labor, respectively, it would appear that the former operation would be required in fifty and the latter in 250 women; and that if the maternal mortality were, respectively, 2 and 1-3 per cent. the numbers of deaths would be identical in both series. On the other hand, admitting that the fetal mortality were 10 and 25 per cent., respectively, five children would be lost in the former and sixty-two in the latter series. Or, to put the matter more forcibly, a greater number of children would have been saved had craniotomy been perforemd in all cases in which pubiotomy was indicated."

"Naturally, it might be suggested by the advocates of the induction of premature labor that such calculations are not convincing. That they are not purely speculative, however, is demonstrated by the figures recently adduced by Burger, which are based upon analysis of 19,000 labors occurring in Schauta's clinic in Vienna. In this series there were 1,240 contracted pelves with a fetal mortality of only 22 per cent. in the cases in which spontaneous labor occurred; whereas it rose to 4.3 per cent. in cases treated expectantly, including all deaths following craniotomy, pubiotomy, and Cesarean section. Results which cannot be approximated by the most enthusiastic advocate of the induction of labor."

"Having shown that pubiotomy is superior to the induction of labor and symphyscotomy, it remains to consider to what extent it enters into competition with Cesarian section. In the first place, it must be stated that the former operation is not indicated when the conjugata vera measures less than 7 cm. Consequently there can be no competition in the pelves above that limit; namely, in the so-called "border-line" cases, in which it is generally impossible to predict the outcome of labor in any given case. Moreover, it must be admitted that if the decision were based entirely upon the general mortality of the two operations, it would have to be given in favor of pubiotomy, as an analysis of the reports of the best operators shows that the average mortality in Cesarean section is in the neighborhood of 5 per cent."

"The researches of Reynolds, however, indicate that this figure does not altogether represent the true state of affairs, but that, admitting the competence of the operator and the excellence of his technic, the results will vary greatly according to the period of labor at which the operation is performed. Thus, in an analysis of 289 cases, he found that the mortality was 1.2, 3.8 or 12 per cent., respectively, according as the operation was performed during the last days of pregnancy, or early or late in labor. As his results are in accordance with my own experience, I feel justified in holding that the results of Cesarean section performed just before or at the very onset of labor are superior to those of pubiotomy, both as regards the actual mortality and ease of convalescence of the mother, not to mention the fact that all of the children are saved, instead of only 95 per cent., as in pubiotomy. On the other hand Cesarean section performed early in labor has a somewhat greater mortality than pubiotomy; while if not resorted to until the second stage is well advanced there can be no comparison between the two operations, as the former has a mortality of 10 or 12 per cent. and the latter of only 2 per cent."

"Accordingly, if it were possible to predict in a given case that engagement would not occur, the best interests of both the mother and child would be served by performing Cesarean section at an appointed time a few days before the expected date of confinement; as by so doing the child would certainly be saved, with a minimal risk and an almost ideal convalescence for the mother. Unfortunately, in the class of pelves under consideration, such a prediction is never possible in women pregnant for the first time and only exceptionally in multiparae. Therefore, in primiparae, Cesarean section would not be indicated at the time of election, unless one were willing to assume the responsibility of operating unnecessarily upon a considerable number of women when one knew by experience that a large proportion of them would be delivered spontaneously if subjected to the test of labor. For this reason, early elective Cesarean section would be justified only in multiparae in

whom the history of previous labors had clearly indicated that nature was habitually unable to overcome the disproportion between the size of the head and the pelvis."

"On the other hand, if Cesarean section is not done at the very onset of labor, I consider that the best interests of the patient will be served if she be treated expectantly, allowed to go into the second stage of labor, and then subjected to pubiotomy, if engagement does not occur after several hours of strong pains, or in the presence of certain conditions which indicate the necessity for prompt delivery."

"To my mind, the great advantage of pubiotomy in the treatment of border-line cases of pelvic contraction consists in the fact that it affords the possibility of subjecting the patient to throes of labor in suitable cases and then of interfering for the sake of the child without subjecting the mother to too great danger. In other words, it enters into competition with high forceps, prophylactic version and craniotomy rather than with Cesarean section."

"I desire to emphasize the fact that if good results are too be obtained, pubiotomy should be regarded as a primary operation, and should not be resorted to after the failure of high forceps or version. If delivery be urgently demanded in such cases, I feel that it is better to perform craniotomy than to subject the mother to any risk for the sake of a child whose life has already been compromised. Moreover, I feel that it should not be employed in cases of infection, as a large part of the fatal results recorded in the literature have occurred in that class of cases."

In an article in the Washington Medical Annals, Vol. III, No. 3, July, 1909, entitled "Some of the Perplexing Complications Found in Gall Stone Surgery," Dr. I. S. Stone, class of 1872, of Washington, D. C., lays emphasis upon the following points: The diagnosis of gall stone diseases is comparatively easy when followed by jaundice, and when a stone is found in the stool; otherwise it is difficult. He refuses to assent to the statement that pressure over the gall bladder with the hand will cause pain if stones are present. He claims ulcer of the stomach or duodenum give rise to symptoms simulating gall-bladder disease, making a positive diagnosis often impossible. The contracted gall-bladder has given the writer the most difficulty in locating both before and after operation. His opinion is that there is no warrant for the removal of a comparatively healthy gall-bladder.

Geo. Hopkins Carr, M. D., Portsmouth, Va., class, 1896, reports the following of cases of lupus, epithelioma, acne and nevus successfully treated with X-ray and high frequency currents:

I have nothing new to present, but desire to show the good results that have followed the use of the X-ray and of the high frequency current in the above conditions, which have often proved intractable and been a source of considerable annoyance to the physician on account of their poor response to the methods in existence before the advent of these new agents.

Lupus Vulgaris.—The patient was a woman sixty years of age, in a fair state of health. The part affected was the ear and an area of two inches below and behind its lower border. The lobe of the ear had been destroyed and the ulcerative process was penetrating deeply at the junction of the ear with the head. There was intense itching and redness; no apple-jelly tubercules typical of this form of lupus were present: they had apparently been destroyed by chemical methods. This form of treatment, however, has been entirely supplanted by the X-ray, through the use of which brilliant results are obtained. I gave this women seances of five minutes' duration, alternating the tube with the high frequency current every other day. After the first exposure the itching was entirely relieved. The amount of X-rays employed was just sufficient to light the tube with a greenish yellow glow; all the time the reaction was kept well below the point of active dermatitis. In this manner tissues of low resistance were destroyed without affecting the healthy stroma. By the continuous use of these weak exposures for a period of two months the case was entirely cured.

Epithelioma.—The patient was a woman sixty years old; the growth was a so-called crater-form epithelioma, the border being very nodular and elevated, with a sharply excavated, deep, central ulcer, involving the left side of the nose. In this case I used the tube exclusively; the seances were of eight to ten minutes duration twice a week, with the tube brought to a greenish yellow glow. After ten weeks of treatment a cure was affected.

Acne in a young man, twenty-two years old. His face was covered with superficial inflammatory papules and pustules, associated with comedones.

I treated him with the ultra-violet light, and constitutional treatment was also resorted to. The seborrhea disappeared first: the formation of comedones and acne lesions gradually ceased, with diminution of the size of the sebaceous follicles, the pores becoming small, and the texture of the skin was entirely restored.

Nevus in an infant, two months old, located on the forehead, extending from the hair to the bridge of the nose. It was a vascular nevus of the flat variety, consisting of a superficial plexus of dilated capillaries. I treated this by the cataphoric method. After painting the nevus with sodium thylate, it was made to penetrate the affected capillaries by the high frequency current. In seven days a scab had formed, and in twenty-one days the nevus came away with the scab, leaving the skin in a normal condition, with the exception of a slight scar that was scarcely visible in thirty days.

Psoriasis.—This was a case of the acute inflammatory form of psoriasis. The lesions were on the extensor surfaces of both forearms, extending from the elbow to the wrist. The eruption had the characteristic red base, slightly elevated, with a sharply circumscribed border. I resorted to the high frequency current exclusively, and with the large surface electrode made applications of five minutes' duration every third day. After five such treatments the eruption completely disappeared.

Rodent Ulcers of the Cornea

(Moren's Ulcer.)

Robert L. Randolph, class of 1884 (J. A. M. A., July 24, 1909), is surprised that so few cases (thirty-five) cases of corneal ulcer (Moren's) are reported in the literature. He believes it is due to a lack of recognition upon the part of the ophthalmologist. At first sight this corneal ulcer does not differ from that form which very ophthalmologist sees now and again, the marginal ulcer. One feature which distinguishes it from any other ulcer of the cornea deeply undermined conjunctival edge of the ulcer. The edges of marginal ulcer are also undermined, but owing t oa better blood supply not to the same extent as the borders of rodent ulcer. Chronicity is an important point in the history of rodent ulcer. Average length of time from two to ten months, occasionally the condition last for more than a year.

It is a mistage to think that the affection is painless, for it is characterized by frequent attacks of suffering and irritative symptoms generally. The ulcer shows considerable to run close and parallel to the limbus of the cornea, and one of its peculiarities is to clear up and look as though it would be completely well in a few days, when a fresh outbreak would occur. The diseased surface is crescentic and bare of epithelium, as a consequence o fwhich the fluorescin stain takes well. Wherever the process has spent itself the cornea is scarred. The disease dies out in most cases after the entire cornea has been involved. Usually seen in adults over 40. Men more prone than women. Its etiology is unknown. He is inclined to the view that it is of bacterial origin. He believes after two months if the ulcer has not yielded to active, irritants such as the galvano cautery it si better to these applications and resort to satl solution, atropine and tonic treatment.

Doctor Samuel Theobald, class of 1867, in the July 10, 1909, issue of the Journal of the American Medical Association, relates that nearly all the ills to which flesh is heir, have been ascribed to eyestrain (Reflex Aural Neuroses caused by Eyestrain), but scant consideration has been given to the influence which it exerts on the auditory apparatus. So scant indeed that he can find no reference to it in the titles of papers contained in the Index-Catalogue of the Surgeon-General's Library. Consequently he has felt it incumbent upon himself to relate his experience in the matter. In enumerating the less common consequences of eyestrain he mentions tinnitus aurium, others which he has observed are a "muffled" or "stuffed" sensation in the ear, pain, not severe, impairment of hearing. Whether vertigo associated with eyestrain, deserves to be regarded as an aural reflex, he is not prepared to say, though it seems not at all improbable that the derangement that gives rise to it is in the semi-circular canals.

The evidence in favor of the ocular origin of the aural sensations enumerated is, first, their disappearance after relief of the eyestrain; second, that the ear affected—for the sensations were commonly unilateral—was usually on the side of the more troublesome eye; and third, that they often became more pronounced when the eyestrain was most annoying. The ocular fault often present was astigmatism.

He appends to the article the notes of four of the most striking of the cases which have come under his observation.

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THE COURSE OF MEDICAL INSTRUCTION. THE IMPROVEMENTS NEEDED.

The great amount of attention which has been given in recent years to laboratory instruction in the education of the medical student has overshadowed, in a measure, the didactic and clinical work which formerly made up the courses of instruction in our medical schools. The brilliant results which have followed from laboratory studies, the scientific cast which they give to the mind of the student, the cultivation of his faculties of observation and research, and clearer insight into the etiology and treatment of disease, have made the laboratory the keystone which gives support to the modern system of education in medicine. The laboratory has not only come to stay, but is destined to exercise a much larger place in the training of the medical student. The word laboratory must be considered in its broadest sense—not as a room equipped simply with microscopes where histology and pathology are studied, but courses of instruction conducted in anatomy, physiology, chemistry and clinical medicine and surgery where laboratory methods are employed. The laboratory is the place where painstaking observations are made, where health and disease are studied side by side with a scientific formula and not with loose and easy methods.

The course of medical instruction is rapidly conforming to the laboratory conception. The text-book, the didactic lecture, the quiz and the oral examination belong largely to the pedagogue; these have a minor place in the curriculum of the future which must consign to the junk shop much rubbish which is now made to take the place of more valuable material. Knowledge of many subjects, formulæ and things is not so much needed by the physician and surgeon as intelligence, correct judgment, scientific ability, the faculty of seeing and appreciating the relations of things and of arriving at practical results. In the education of the medical student his knowledge of subjects should be exact, but this knowledge should be of that character which is in constant use, which has direct relation to the practice of that branch or to those branches of science in which he is chiefly employed. Much of the material which is now crammed into the mind of the student could be and should be cut out if the aim of the student's future work can be ascertained. In every class of medical students there are not a few men who have definite courses in view; a few are destined to follow the scientific laboratory — pathological, physiological or chemical; a few others specialize in medicine, surgery or their minor fields, whilst the larger majority will express their purpose of engaging in general practice. It seems clear that a course of education which holds an entire class to the same line of study, making no exceptions for the laboratory man or the clinician is following old and impractical methods. The time is fast coming when such systems must give way to broader and more enlightened views. Why postpone specialization in medical study until after graduation, when it might be inaugurated with marked advantage to the student during the years of preparation for the doctorate?

After the fundamental sciences have been well taught the field of work might well be narrowed to cut out on the one hand, or to emphasize on the other, those lines of work which may be unnecessary or necessary to the man in his future career. The most marked success now being made by men in all avocations and professions will be found in that class who do not possess so wide and varied a knowledge of many things as an accurate, practical and clear knowledge of the work in which they are engaged.

Knowledge is not skill, nor is it wisdom. It is only a valuable asset when it is used skillfully and wisely. The time expended in acquiring knowledge will be well spent or poorly spent in proportion as this knowledge is made use of by the individual, but a training which stimulates

a mind to think, to observe, to judge, and to act, will always give an asset to the individual which will pass at its par value in any market. If the education of the student enables him to acquire a habit of mind which fits him to see and judge facts in their true relations, to know the true from the false, to discriminate and adjust, to have loyalty and mental endurance, the highest standard of instruction has been reached.

THE PHYSICIAN IN POLITICS.

It is unfortunate for the medical profession and still more, we believe, for the public interests, that few physicians are found in legislative bodies, either state or national. These few, as a rule, are young men seeking local popularity, or older men retired from the active practice of medicine or engaged in other pursuits. There is an apparent antagonism between the active practice of medicine and the occupancy of public office. The constant demands upon the time of the physician engaged in a busy professional work make the holding of a public office a question of personal sacrifice of business which but few men will agree to. The physician in politics must either be a man who is simply interested in public matters without holding public office or the man who accepts public office to the neglect of his professional interests. The result of this condition of things has tended to lower the professional standard of the physician in politics in the respect and confidence not only of his professional brothers, but of his patients and neighbors. There is no substantial reason why this feeling should exist and it is unfortunate not only for the medical profession, but for the public, that it does, since it has deprived the state and nation of a class of men whose training and experience could have been made extremely valuable in the public service. It has forced the leading members of the profession of recognized professional ability and large accomplishments to take no active part in the making of useful laws and in promoting the best interests of citizenship by an active co-operation in civic affairs.

In looking over our numerous state and national legislative bodies one is struck with the small representation of the medical profession in contrast with that of other professions and occupations. Lawyers, capitalists, bankers, farmers and even clergymen, are more largely represented in these bodies than are physicians, scientists and educators; men who by training and mental discipline are most eminently fitted for public life and public service. In the present Senate of the United States there is only one trained physician, and it is well known how wisely and well he has served the nation. In the House of Representatives one can count on his fingers all the physicians in this body and yet find no man who has made distinction in his profession outside his own district.

In the Cabinet we fail to find in the long list of men who have been advisers of the President the name of a single physician. In the early history of the Republic Benjamin Rush not only served the nation with eminent ability, but was a distinguished ornament to the profession of medicine, and taught the lesson that the physician in politics was equally skilled in the duties of the sick room. He found ample time to attend his patients, to contribute to the literature of his profession and to serve the nation in the most critical period of its existence.

Benjamin Franklin, philosopher, scientist and statesman, whilst not a physician, demonstrated that wide and varied talents enlisted in the public service gave dignity and authority not only to the man, but to positions he filled in public office.

In Great Britain one cannot but be struck with the small part the medical profession has played in the political history of this great nation. Whilst Harvey, Jenner, Hunter, Simpson, Lister and many noted men have brought great honor and glory to the English-speaking race, we find no Harvey in Parliament making laws and no Jenner in the House of Lords contending for established privileges. The physician in politics in Great Britain has made no distinction and has rendered but little public service.

In France both physician and scientist have engaged with striking loyalty and efficiency in public service and, perhaps, in no nation has the medical profession been more largely and ably represented in legislation and in administration. The French people have dignified both medicine and general science by the high regard it bestows upon men who became eminent as investigators or as leaders of thought and action. She has honored with the highest public office many of her most noted physicians. In Germany the late

Prof. Virchow is a striking illustration of the greatest of scientists and the greatest of citizens. It is doubtful whether his contributions to pathology, which have become the property of the entire world, are held in higher esteem by the German people than his civic virtues, his manly independence and profound patriotism.

The German people know that Virchow loved and served Germany as much as he loved science and that he gave his best labors to both. With these general statements of conditions which have influenced the participation of the physician in politics, it is pertinent to ask whether these conditions should continue or whether the time has not come for larger and more liberal views on the subject. In an age of such progress as the world now enjoys men of training, of talent and of fitness are needed in every walk of life. The functions of government are becoming more and more complicated each day. The laws, customs and business interests of the people are being changed to meet industrial and social establishments which spring up over night and threaten the stability of older thought and action. This social and industrial evolution brings money and class distinction into the limelight, and makes organization and co-operation essential to an honest and efficient administration in civil government. The men who control political parties, who make our laws and who govern the people are largely put in these positions of trust and responsibility through influences organized and controlled by corporate or personal interests. The people at large who vote and make majorities are, as a class, indifferent to general results so long as they are not personally disturbed in their property interests. A law, however unjust or bad, is not vicious except to the individual who is prejudicially effected by it. A high tariff is only detested by people who seek the benefits of the low tariff. In other words, the question of legislation is very largely determined by personal interests and considerations, and these matters usually influence the election of men who make our laws and govern our affairs.

So long as the people, as a body, do not concern themselves in a serious way about political questions, just so long will legislation follow the channels made by personal interests. If able and efficient men are so much interested in their private affairs as to be unwilling to render public service, what right have they to expect personal consideration by men who may have their own personal interests in direct conflict with theirs?

If the medical profession desires legislation along lines in accord with the highest public and professional interest, it must assert its influence through personal representation in legislative bodies.

Some of its best men must be willing to make a personal sacrifice by accepting public office, and by lending their best influence in behalf of the highest citizenship. If the profession has no civic pride or loyalty and seeks to escape personal responsibility in public service, it should not complain if legislation does not go its way.

No body of men is in better position to direct the public mind and to promote the highest standard of citizenship than are medical men. They know the needs of the people and are nearer to the hearts of the people than any other class. It is up to the profession to say whether the physician in politics shall command the co-operation and respect of his brother physicians when he consents to render a public service, or whether his efficiency shall be weakened by indifference and adverse criticism. T. A. A.

CORRESPONDENCE

AMERICAN ASSOCIATION OF CLINICAL RESEARCH.

Editor Hospital Bulletin,

Dear Sir:

There is a movement on foot to establish an American Association of Clinical Research for the purpose, first, of ascertaining the present exact status of clinical medicine and surgery, and, secondly, of advancing clinical medicine and surgery, by the conjoined clinical method or any other method that will insure exact and abiding results.

Will you have the kindness to publish the accompanying open letter in the next or the earliest possible issue of your Journal?

The meeting is called for October 27 next, and your assistance in calling attention to this meeting sufficiently early will be highly appreciated as an effort to help the cause of scientific medicine and surgery.

OPEN LETTER.

Dear Doctor:

A meeting of physicians and surgeons interested in Scientific Clinical Research is called for Wednesday, October 27, 1909, at John Ware Hall, Boston Medical Library, No. 8 Fenway, Boston, Massachusetts. The meeting will come to order at 10 A. M., and carry its sessions through Wednesday, and, if necessary, through Thursday and Friday.

The object of the meeting is,

First, to establish an American Association of Clinical Research;

Secondly, to establish clinical research on an incontrovertible scientific basis in hospitals; and

Thirdly, to institute an American Journal of Clinical Research, in which the work of members of the American Association and of others doing clinical research work in a scientific manner shall be published.

You and your friends are herewith cordially invited to participate in this meeting and in the proposed movement of scientific clinical research.

This invitation is extended to all physicians and surgeons whose interest goes beyond the immediate case work of ordinary clinical societies; and it is hoped that the invitation will be accepted by all medical practitioners, irrespective of their present medical affiliations, who can appreciate the necessity for establishing on an incontrovertible scientific basis the certainties and limitations of the present practice of medicine and surgery before attempting to add to the already large and cumbersome field of medicine.

The American Association of Clinical Research is not intended to disturb the present medical affiliations of its members nor to interfere in the very least with the duties they owe and the privileges they enjoy by virtue of their affiliation with any existing national medical body.

The American Association of Clinical Research is to take cognizance of the fact that the clinic requires cold facts and conclusive methods, and upon these fundamental requirements, the structure and the work of the American Association of Clinical Research are to be built.

It is of the utmost scientific importance to establish conclusively all that is at present true in medicine and surgery, and only upon such proved knowledge, to base any further advancement. The clinic deals with clinical entities and not, like the laboratories, with parts as entities. Therefore, clinical research differs, and must differ, from experimental laboratory researches. Clinical research must consider clinical entities, and when considering parts, it must consider them only as parts and not as wholes. All that subserves the object of obtaining and investigating clinical facts and principles belongs to clinical research and the laboratory is a part of the means of clinical research, but only a part.

The crux of the matter appears to be that experimental laboratory proof is not sufficient clinical proof. In order to advance in an irresistible line, clinical research must be based on a conclusive form or method of clinical proof. In experimental proof, we dislocate a part from a whole and attempt to prove the whole from the part, as though a dislocated part could always prove the whole. Or we attempt to prove facts in one species by facts in another species, as though the two species were identical. For instance, the experiments made on animals to elucidate certain elements of fever bring out a fact of almost insurmountable difference between man and the lower animals, the fact that man has associated with the nakedness of his body a highly perfected power for regulating his temperature, a highly developed vasomotor system and a vast array of sweat glands, a characteristic complex of things which apparently no other species of animal life presents. Experiments made on animals to prove febrile or other clinical phenomena in man, may be suggestive, but for obvious reasons cannot be conclusive. To prove observations in man, the observations must be made on man and not on animals. But observations on man even are not necessarily conclusive. Individual observations on man cannot be conclusive, because the same experience cannot be repeated, and when we prove by numbers, we compare similar but not identical experiences. Analogy is not conclusive proof. Identity alone is conclusive proof; but since, in medicine, identical experiences cannot be repeated, we must provide simultaneous identical experiences in order to have proof by identity. Clinical proof is conclusively established when all observations and experiments are made conjointly by at least two competent men, preferably of opposite ideas, at the same time. Conjoined critical observation and experiment, at the bedside and in the laboratory, as may be required, furnish simultaneous identical experiences, the proof proceeding on the principle that a whole

can be proved only by the whole and not by dislocated parts.

These and other weighty questions await your assistance for a necessary solution. The benefit that will accrue, both to medicine in particular and to the medical profession and humanity at large in general, from a satisfactory establishment of scientific clinical research, can be easily surmised. Come prepared, yourself and your friends, to give to this matter your mature convictions and your personal assistance. Only from a critical interchange of critically acquired opinions, can we hope for clearness and for the clarification of the medical atmosphere now charged with confusion and indifference.

Your communication, indicating your interest and your expectation of being present at the meeting in Boston on October 27, next, is eagerly awaited, and on receipt of the expression of your interest, further developments will be communicated to you personally in due time.

Please address your communications at the earliest possible date directly to James Krauss, M. D., 119 Boylston Street, Boston, Mass.

Yours fraternally,

(Signed) James Krauss, M. D.,

Chairman Committee American Association Clinical Research.

119 Boylston Street, Boston.

August 18, 1909.

MEDICINE IN GENEVA AND THE CALVIN FETES.

To the Editor of the Hospital Bulletin:

Called upon to represent the University of Maryland on the occasion of the University Jubilee at Geneva, Switzerland, I found myself early in July comfortably established at the National Hotel, a hostelry charmingly situated on the margin of the Lake of Geneva. Arriving somewhat ahead of time, owing to misleading accounts in the Swiss papers as to the order of events, I was able to see a little of two other fetes which took place about the same time, the Commemoration of the Foundation of the Geneva Protestant Church, and the laying of the cornerstone of the Monument to the Reformers, and the 350th anniversary of the founding of the Academy or College by John Calvin and Theodore de Beye, which latter took place on June 5, 1559. Strictly speaking, Geneva cannot lay claim to being a very old University. Recent writers put the date at 1875 or 1876, so that it does not compare in age with many of our American universities, nor can it be mentioned in the same breath with those of Bologna, Paris and Oxford, which are certainly 800 years old. Nevertheless there is no doubt that the "Academies" founded in 1559 by Calvin, became eventually the University of Geneva, and that in those remote times Calvin was lecturing to more than a thousand students, among his pupils being John Strong, the Scottish Reformer; Thomas Bodley, the founder of the Bodleian Library at Oxford, and Jean Jacques Rousseau, whose writings, more than any others, inspired the French Revolution. Nor can there be any doubt that during the comparatively few years of Calvin's life in Geneva he exercised an influence on general education on the Christian Religion, and on the political life of the State, that many have been disposed to underestimate. Calvin and de Beye, the first Restorers of the Academy, were, in many respects, the most remarkable men of their time. Calvin was never a popular man in the sense in which we use the word; other Reformers were certainly of far more lovable disposition, but he had remarkable endowments, and possessed great strength of character. Of a clear and logical mind, he had the power of expressing himself, both as a writer and speaker, and a style of composition that has seldom been equalled. He was also a born teacher, having not only the ability to attract large audiences, but to retain their attention and interest. In de Beye or Beya, as he is perhaps more often called, Calvin had a coadjutant, committed to his view, both willing and able to carry out the details of instruction under orders from his chief. The martyrdom of Michael Servetus, the distinguished physician and anatomist, must be judged in the light of Calvin's character and the spirit of those times when discoveries in medicine were viewed with alarm. After all, as a man said to me when discussing the question, "the other fellows (meaning the Catholics) would have burned him if they had the chance." Death at the stake was to the popular mind a proper punishment for the man who held such heterodox opinions.

A fact that interests us Americans, especially where new universities are springing up, or are made by associations of heterogeneous elements, that lose much of their efficiency through lack of co-ordination, is that Calvin and De Beye had

from the first, even in their earlier times, when the Academy was started, the idea of what a University should be. Though they had neither the qualified teachers or the funds to carry out their ideas, they laid the cornerstone for the University of Geneva on a solid foundation. Their personal qualities were their capital, for they had neither laboratories, museums, or elaborate physical appliances. To them is due the introduction of class studies into general education. Dividing the students into groups, according to their ability to assimilate, rather than according to age, led to the "promotions" which exist under the same name today in the University of Geneva. "Promotions" according to the Swiss idea is the advancement of students from a lower to a higher class, after passing test examinations. Previous to this introduction of graded courses, students were taught in a mass, without regard to age or qualifications.

In 1533 Calvin had been the central figure of the Reformation in France, his native country. He was then 24 years of age. Three years later—in 1536—he published his "Institutes of the Christian Religion." In 1537 he settled in Geneva and lived there until his death in 1564, at the comparatively early age of 55. During most of his life he was a great sufferer, his chief ailments being consumption and stone in the bladder.

Fiske had called him the Father of Coligny, William the Silent and Oliver Cromwell. And this judgment of him seems to have influenced the committee which had in hand the planning of the Reformer's Monument, the cornerstone of which was laid opposite the University, with much ceremony, on July 6. This monument, when completed, will represent in colossal size Farel the Reformer, Calvin, De Beye and John Strong, while flanking them on either side will be smaller figures of Oliver Cromwell, William the Silent, Frederick William of Brandenburg and our American Roger Williams.

It was noticeable that in all three celebrations Calvin was the central figure. The people both of city and State appeared to have forgotten his seeming intolerance and tyranny, or felt that they had been sufficiently expiated by the monument they had recently erected to the great Servetus, and it was none the less a little surprising to the foreign delegate to hear Calvin lauded by Protestants and Catholics alike. Deucher, the venerable President of the Swiss Republic and a Catholic, in an eloquent address at the dinner given by the University, spoke of Calvin as the man who taught citizens to be conscientious and moral, and on the same occasion other State officials, also Catholics, credited him with an influence for good which they hoped might live. To the modern Swiss Calvin is the Washington, to whom they owe their present democratic form of government.

The University of Geneva came early into prominence through the number and ability of its theologians, later through its departments of Law, Philosophy and Literature. The School of Medicine is of comparatively recent creation, though among its professors have been Carl Vogt and Edward Claparede, comparative anatomists; Harmon Fol, the embryologist, and Sigismund Laskowski, the anatomist. Its present teachers of practical medicine and surgery are unknown to us, but, after all, Geneva is a city whose population in 1907 was not more than 120,000. This is, perhaps, the reason the United States had among its 29 delegates only two medical men, Dr. W. H. Welsh, representing the Carnegie Institution, and myself. Most of the delegates were theologians of various sects. Perhaps the most interesting and noteworthy ceremony was held in the old St. Peter's Cathedral on July 8, when delegates representing 24 countries, and 220 universities, learned societies or associations presented their addresses before an audience that filled the building to overflowing. Dressed, the greater number in their academic gowns, or robes, representative of an office or society, the brilliant display of color made a most effective picture against the sombre background of the grey old Cathedral. Each delegate, as he was called, advanced to the rostrum, addressed a few complimentary words to the audience, and handing his written address to the Rector, shook hands with him, and then retired to stand again with his delegation until each of its number had been heard from, when they returned to their seats and gave place to the next delegation.

French being the official language of the University, most of the delegates spoke in that language. Occasionally German was used, and one delegate spoke in Latin.

Baltimore and Washington were the only cities of our States represented by medical delegates. Other representatives of our large cities were a

number of Presidents of Colleges and Seminaries, and men of note generally. The complimentary degrees of Doctors of Medicine, causea honoraris, were 25 in number, one only coming to the United States. It was conferred upon Loeb, of California, presumably for his work in physiology. Among those honored were M. Cewire, of Paris, for his discoveries of radia, active substances, and his work on radium; Dejerine, of Paris, for his work on the anatomical changes in diseases of the nervous system; Dufour, the celebrated oculist of Lausanne and Garre of St Gall, for his works on the bacteriology of tuberculosis affections; Van Gebuchten, of Lourain, Belguim, for his researches on the anatomy of the central nervous system; Golgi, of Paris, for his researches on the structure of nerve cells; Lister, for his antiseptic methods; Pawlof, of St. Petersburg, for his discoveries as to the functions of the stomach; Sahli, of Berne, for his notes on Internal Medicine; Waller, of England, for his studies on the physiology of bees. Among others honorder were Guyot, the French surgeon; Haeckel, of Jena, the comparative anatomist; Kollmann, the embryologist, of Bales; Kronecker, the physiologist, of Berne; Recklinghousen, the bacteria pathologist, of Strassberg, and Ketzius, the histologist, of Stockholm. Original work, especially in anatomy or physiology, seemed to be regarded as the most worthy of honor.

Delegates and noted guests to the number of over 100 were entertained by the University, city and State, acting jointly. The fetes as a whole began on July 26 and continued without interruption until the night of the 10th, when a grand "Commers" by the students brought the festivities to a close in a blaze of glory. Notwithstanding most unpropitious weather during the Jubilees, the final verdict will be, I am sure, that the fetes were a success. The elaborate entertainments that were provided day after day and the generous hospitality of our hosts will be long and pleasantly remembered, both by delegates and guests.

Thomas G. Satterthwaite, M. D., LL. D.,
7 East 80th street, New York City.

ITEMS.

Doctor Lot Ridgely Wilson, class of 1880, is a native of Baltimore, in which city he has engaged in the practice of medicine for more than twenty-five years. He was born June 9, 1858, and is the son of John W. and Sarah J. Ridgely Wilson. His earlier education was obtained in the public schools of Baltimore and Milton Academy, his medical in the University of Maryland, whence he graduated with the class of 1880. Since graduation his time has been devoted to the general practice of medicine. He is medical examiner for The Shield of Honor Life Insurance and is a member of the Flint Club. He is a Mason. He married Annie R. Mercier, by whom he has a daughter, Mareese Wilson.

Doctor Horace Melville Simmons, class of 1881, of Baltimore, was born in West Bedford, Coshocton county, Ohio, June 30, 1854. He was the third son in a family of six children. His father a physician, emigrated from Maryland in early boyhood, and at the age of twenty-seven entered upon the practice of medicine in Ohio.

Doctor Horace Simmons received his early education in Deersville, Harrison county, Ohio. Later he entered the office of the "Cadiz Republican." After three years of practical experience in editing and publishing, he accepted an engagement with the "Coshocton Democrat." He matriculated in the Medical Department of the University of Maryland in 1879, and received the degree of Doctor of Medicine in 1881. After graduating he returned to Ohio to enter into copartnership with his father, in which connection he continued until 1882, when he returned to Baltimore to enter practice. In 1883 he married Miss V. Estelle Dunning, daughter of the late Reverend Halsey Dunning, a Presbyterian clergyman of Baltimore. One son survives this marriage, Halsey Melville Simmons. Mrs. Simmons died in 1895.

Doctor Simmons was again married in 1903 to Miss Caroline Frazier Johnson, of Baltimore, and resides at 1706 Park avenue, Baltimore.

In 1893 he organized the Health Magazine Company, of Baltimore and Washington, to publish the "Popular Health Magazine." The year following this company acquired the ownership of the "Maryland Medical Journal," and both publications continued under his management until 1898, when the "Health Magazine" was disposed of to a New York company. In July, 1906, Dr. Simmons acquired a controlling interest in the "Medical Review of Reviews," inc., New York and London. In 1909, he relinguished the management of the "Maryland Medical Journal" to Dr. Nathan Winslow, class of 1901, so that he might be able to devote his entire energies to the "Review."

Doctor John S. Fulton, class of 1881, professor of State medicine in the University of Maryland, was born in 1859, at Fremont, Ohio. He is the oldest son of Reverend William Fulton, D. D., of Glasgow, Scotland, and his wife, Nancy Organ, of Cable, Ohio. He came to Maryland in 1863, when his father became rector of All Hallows' Parish, Snow Hill. He removed to Salisbury, Md., in 1869. In 1872 he entered St. John's College, Annapolis, Md., graduating in 1876, then entered the office of Dr. Stephen P. Dennis, Salisbury, as a student of medicine and taught in the public schools for two years. He then entered the medical department of the University of Maryland, where he was graduated in 1881. From 1881 to 1887 he practiced at Lakeville, Dorchester county, Md., and in Salisbury, 1887 to 1895. In the latter year he moved to Baltimore and became chief of clinics in internal medicine at the University Hospital Dispensary and later clinical professor of Medicine. In November, 1896, he was made secretary of the State Board of Health of Maryland, and in 1902 was appointed professor of State Medicine in the University of Maryland. About 1906 he resigned the secretaryship to the State Board of Health to become secretary of the International Congress on Tuberculosis, in which position he displayed marked executive ability and generalship. Doctor Fulton married in 1888, Nancy Helen White, of Salisbury, Md.

Dr. John Homer Hoffman was born in Baltimore, August 17, 1857. He is a son of Dr. Daniel P. and Maria Burot Hilbert Hoffman. His literary education was obtained at Loyola College, Baltimore, and his professional in the medical department of the University of Maryland, whence he was graduated with the class of 1881. Since which time he has been engaged in active practice in his native city. Doctor Hoffman is a member of the Roman Catholic Church, the Crescent Club and at one time was a member of the Baltimore Clinical Society. In September, 1883, he married Miss Susie L. Burke, by which union he has begotten four children—May L., Reginald K., Alma L. and Joseph D. Hoffman

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Doctor Caleb N. Athey, class of 1891, of Baltimore, was married to Miss Helen Skipwith Wilmer, a graduate of the Johns Hopkins Training School for Nurses, August 3, 1909.

Doctor Walter Van S. Levy, class of 1904, formerly of Baltimore, but now of Stonleigh Court, Washington, District of Columbia, has applied to the Circuit Court No. 2 to have his surname changed to Van Swearingen, a family name. The petition states Dr. Levy is a Gentile; is he, and the name signifies a person of Jewish extraction. An order signed by Judge Henisler requires cause to be shown by October 4, 1909, why the petition should not be granted.

Doctor Edward A. Wareham, of Hagerstown, Md., made a short address upon "Grip," at the Seventh Annual Convention of the Cumberland Valley Medical Association. Doctor J. Walker Hunnichouse, class of 1873, was one of the committee on arrangements. Doctor Michael J. McKinnon, a venerable physician, of York, Pa., is seriously ill at his home.

Doctor Alberto L. Bartlett has the honor of announcing that he has been nominated the local head of the National Sanitary Board. Doctor Bartlett is located at Placetas, Cuba.

Doctor and Mrs. T. B. Marden are making an extensive trip through the West.

Doctor Summerfield B. Bond was recently elected vice-president of the Baltimore and Ohio Association of Railway Surgeons.

Doctor Somerset R. Waters, of Mt. Airy, Md., is a candidate for the House of Delegates from Carroll county upon the Democratic ticket.

Dr. Joshua W. Hering, who was re-nominated for Comptroller of the State Treasury, was probably the oldest man of prominence at the recent Maryland State Democratic convention. He was born in Frederick county 76 years ago. Great as has been the demand upon his time as a physician, regardless of the hour of day or night, he has found time to take active part in religion, education, finance and politics. In every field he has gained distinction and honors.

After studying in the public schools of his native county, he, as a boy, started to work in a store, but decided that he would rather be a physician. He began the study of medicine under the private tutorship of Dr. William A. Mathias, at that time a prominent practitioner in Westminster. He then

came to Baltimore and took the course at the Maryland University, getting his degree in medicine in 1855. Returning to Westminster he soon built up a lucrative practice and prospered in the business enterprises in which he became interested. In 1867 he was chosen cashier of the Union National Bank of Westminster. His prominence among the bankers of the State, aside from his other interests, was such that in 1899 he was elected president of the Maryland Bankers' Association.

A devout churchman, he was given one honor after another by the Maryland and general conferences of the Methodist Protestant Church. In 1892 he was elected president of the General Conference, the only layman who ever held that position. Dr. Hering has always been intensely interested in the welfare of Western Maryland College, at Westminster, which is connected with his church. He is the president of the board of trustees and the only living charter member of that board. He was given the degree of master of arts by Western Maryland College in 1885 and the degree of doctor of laws by St. John's College in 1900.

Although always a stanch Democrat and one of the most popular men in the party in the State, it was not until 1896 that he accepted office. In that year he was elected to the State Senate. He was first elected Comptroller of the State Treasury in 1899. In 1901 he was re-elected, but declined the nomination. He was re-elected in 1907, and now he has been re-nominated to serve a fourth term in that office.

Dr. William J. Todd read an interesting paper at the recent meeting of the Baltimore County Medical Association, held at Towson, on the life of the late Dr. Josiah S. Bowen, the pioneer physician of Mount Washington, who did much toward the development of that place. Dr. Bowen was born on March 1, 1832, on the Hillen road. In early life he was a general contractor, and in 1854 he went to California and shared the hardships and adventures of the gold seekers there.

In 1860 Dr. Bowen returned to Maryland. In 1865 he graduated at the medical department of the University of Maryland. The same year he located at Mount Washington, and became one of its leading citizens. In conclusion Dr. Todd said:

"It can be said of Dr. Bowen that his life was quiet, industrious and unassuming, and that it was a success, because in his long and active practice he relieved the sufferings of the sick and added comfort to the poor and the afflicted. I recall the shock to me and the community of his sudden death, being found dead in his chair on the morning of August 29, 1900, after arranging for the business of the day—actually dying in the harness."

Dr. Josiah S. Bowen, class of 1903, of Mount Washington, is a son of Dr. Bowen.

Dr. Benjamin F. Bussey, class of 1885, president of the Association, presided at the meeting.

Doctor James A. Shackelford, class of 1876, of Greenville, Mississippi, died at the home of his nephew in Carrollton, Mississippi, July 10, 1909.

Reverend Edward Mortimer Hardcastle, class of 1889, of the University of Maryland, died at his home in Easton, August 15, 1909, of consumption, aged 42.

Doctor Byron Clark, class of 1881, formerly professor of theory and practice of medicine in the Eclectic Medical College of the City of New York, died at his home in Washington, Pennsylvania, August 5, 1909, from diabetes, aged 72.

Doctor Marshall B. West, class of 1901, has bought of Elias Livezy a residence and two-acre lot on the east side of Ingleside avenue, Catonsville.

Doctor J. Frank Crouch has purchased from Pierre C. Dugan and Nephew, real estate brokers, representing Thomas O'Neill, a parcel of seventeen acres from the large tract of land recently purchased by Mr. O'Neill on the Severn river. The land is beautifully situated at the junction of Cold Spring Creek and the Severn river and is known as Long Point. It is the intention of Dr. Crouch to improve the land and erect a beautiful summer residence, for which he is having plans prepared.

Doctor Taylor E. Darby, class of 1904, of Barnesville, Maryland, was one of the successful candidates before the last examination of the Army Medical Examining Board, for a commission of second lieutenant in the Medical Corps of the United States Army. He will be stationed at the Army Medical School, Washington, for a year when he will take the examination for a first lieutenancy.

"Dr. Arthur E. Ewens, who was elected Supreme Medical Director at the recent session of The Supreme Ruling, is, in the language of Brother H. K. Eaton, who nominated him for this important office, 'of sterling qualities and unimpeachable integrity, occupying a pre-eminent position both as a man and as a physician.'

"The history of the University of Maryland, Vol. 2, p. 477, gives much interesting information in regard to his achievements and his high standing in his profession. He is a graduate of the State College of Maryland (his native State), at which College he received the degree of Bachelor of Science and was awarded the gold medal for the best graduation thesis. Upon the completion of his college course he entered the Medcial Department of the University of Maryland, from which institution he graduated with honor in a class of 150, receiving the degree of Doctor of Medicine. Immediately following his graduation he took a competitive examination for appointment as resident physician and surgeon to the Atlantic City (N. J.) Hospital, receiving first place and serving in the above position for one year. He enjoys the distinction of having received one of the highest averages ever made before the New Jersey State Board of Medical Examiners, which is universally recognized as maintaining a very high standard. At the time he took this examination 72 physicians came before the Board for examination, and the Doctor was one of only two physicians who attained an average of over 90 per cent. In recognition of this remarkable record, his name was sent to the Governor of New Jersey to receive honorable mention.

"At the expiration of his first four years in the practice of medicine he was chosen out of 150 Atlantic City physicians for the high and responsible position of Surgeon to the Atlantic City Hospital, his election being unanimous. For some time he held the position of Medical Inspector of Public Schools in Atlantic City. He is also Visiting Physician and Surgeon to the Foster Home for Orphans at Longport, N. J.

"Dr. Ewens is a member of the following Medical Societies: The Atlantic County Medical Society; Medical Society of the State of New Jersey; American Medical Association; Atlantic City Academy of Medicine, and the American Academy of Medicine and Medical Club of Philadelphia.

"That he is a true Fraternalist is conclusively indicated from the fact that he is a member of the Fraternal Mystic Circle; Ancient Order of United Workmen; Modern Woodmen of America; Brotherhood of the Union; Patriotic Order of the Sons of America; Bata Mu Chapter of Phi Gamma Delta Fraternity at the Johns Hopkins University (where the Doctor took a post-graduate course), and he is also a member of Belcher Lodge, No. 180, of Free and Accepted Masons, Atlantic City, N. J.

"As Worthy Medical Examiner for the Fraternal Mystic Circle his is a most remarkable record. While he has examined between 300 and 400 applicants during the past three years, so carefully, skillfully and conscientiously has his work been conducted that up to the present time there has not been a single death. He is a member of Progressive Ruling, No. 890, at Atlantic City, N. J., in connection with which Ruling this splendid record was achieved.

"Dr. Ewens has entered actively and earnestly upon the duties of his office, and it can safely be predicted that he will achieve the same satisfactory results in this responsible position which he has in every other one he has ever occupied."

The State Board of Medical Examiners of North Carolina, which met at Asheville June 9, 1909, announce that Doctor Branch Craig, class of 1909, of Salisbury, North Carolina, attained the highest grade, 95 6-7 per cent. Those of our school appearing before the Board successfully are:

Doctors—

Robert W. Crawford, class of 1906, of Rocky Mount.
G. D. Moose, class of 1907, of Wilson.
D. C. Absher, class of 1909, of Obids.
Asa Thurston, class of 1909, of Taylorsville.
James L. Moorefield, class of 1909, of Guilford College.
Robert S. McElwee, class of 1909, of Statesville.
C. L. Swindell, class of 1909, of Kinston.
Edgar M. Long, class of 1909, of Hamilton.
J. E. Dowdy, class of 1909, of Winston-Salem.
J. D. Weatherly, class of 1909, of Kernersville.
Fred. Wharton Rankin, class of 1909, of Mooreville.
Branch Craig, class of 1909, of Salisbury.

We are pleased to announce that all candidates from University of Maryland of the class of 1909 appearing before the North Carolina State Board of Medical Examiners did the school the honor of

receiving their licensure. Indeed, out of thirteen appearing before the Board only one of class of 1904 failed to receive his license.

Doctor John S. McKee, class of 1907, of Raleigh, North Carolina, is taking the Post-Graduate Course at the University of Maryland.

Doctor Thomas Eben Reeks, class of 1901, of New Britain, Connecticut, who recently had a gastro-enterostomy made on him by the Mayo Brothers, has been spending a few days in Baltimore. He is looking hale and hearty and does not look the invalid.

Doctor Henry McKee Tucker, class of 1899, of Raleigh, North Carolina, stopped off recently on his way to New York, to take a Post-Graduate course. He reports that he has succeeded in building up a nice practice. This will be good news to Dr. Tucker's numerous friends.

Doctor James Lee Hopkins, class of 1897, of Havre de Grace, Maryland, paid a hurried visit to the University Hospital recently. He is looking hale and hearty.

Doctor Walter Van S. Levy, class of 1904, of Baltimore, has been appointed visiting pathologists to Freedman's Hospital, Washington, as a result of a competitive Civil Service examination. It is reported that he was the only eligible out of fifty candidates.

Doctor C. E. Kriete, of Aberdeen, Maryland, has been appointed an official of the Harford County Marathon.

Doctor James M. Craighill, Clinical Professor of Medicine, has returned from Canada.

Doctor William E. Martin, a prominent member of the class of 1909, of Harrisonville, Md., has issued an announcement that he was married to Miss Hannah Bailey, of Easton, Md., September 25, 1907. Dr. Martin, who is the son of Mr. and Mrs. William Martin, of Sykesville, Md., met Miss Bailey in 1904, while she was studying to be a trained nurse in the Springfield Hospital. They were married at Chambersburg by the Reverend Doctor Glenn, pastor of the Methodist Episcopal Church there. Doctor and Mrs. Martin will make their home at Harrisonville, where the Doctor will engage in the practice of his profession.

DEATHS.

Doctor James Bordley, class of 1868, one of Queen Anne's county's most prominent physicians, died at his home, in Centreville, on the afternoon of August 30, 1909, after a lingering illness. Doctor Bordley was born in Centreville, March 14, 1846, and was taken by his parents in 1849 to Baltimore, where he remained until 1861. He then entered St. John's College, now the department of Arts and Sciences of the University of Maryland, but when the war began he commenced the study of medicine at the University of Maryland. After his graduation in 1868 he opened an office in Centreville, where he has since successfully engaged in practice. He was elected the second president of the Maryland State Board of Medical Examiners, serving from 1893 until his resignation in 1896. He was at one time president of the Queen Anne's County Medical Society. For years he was a director of Centreville National Bank. At the time of his death he was president of the Building and Loan Association of Queen Anne's County.

In 1868 Doctor Bordley married Miss Henrietta M. Chamberlaine, of Cecil county, who died within a year. In 1871 he married as his second wife, Miss Ella F. Brown. By this union was begotten three children—Madison Brown, who is a graduate of the University of Maryland and now clerk to the County Commissioners for Queen Anne's county; Doctor James Bordley, Jr., who is a graduate of the Medical Department of the University of Maryland, class of 1896, and an ex-resident of Bay View Asylum, and Mercello Worthington, who is a graduate of St. John's College.

In connection with his professional and other duties, Doctor Bordley superintended the operation of his farms in Queen Anne's county. He was counted one of the most successful and energetic business men as well as one of the leading physicians of the Eastern Shore of Maryland. He was a prominent member of many societies and was their medical examiner. In politics he was a stanch Democrat.

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A SERMON TO STUDENTS AT THE BEGINNING OF THE SCHOOL YEAR.

By Rev. Jesse Hill,

Pastor of the Williston Congregational Church, Portland, Maine.

Learn to do well.—*Isaiah* 1:17.

The Biblical writers are always in their glory when they are delineating the growth of human character. The different stages of character unfolding was one of their chief delights, and they are never more charming than when picturing the progress of a man from his lesser to his greater self. They were lovers of a well-balanced manhood. In all their figures of speech and descriptions they represent life as a great effort. Life is a struggle. The discipline, the toil and drudgery are represented as having a very beneficent influence in the development of character. Dr. Drummond declares that the great allies of progress are want and hunger; that the inertia of things is such that without compulsion they will never move. He compares the evolution of a man to the experience of a little bird in a city park, whose day is spent in getting a living. It awakens at daybreak and sets out to get its breakfast, but another bird has been awake before it, and it has lost its chance. With 30 other breakfastless birds he must bide his time, scour the country, prospect the streets, the grass, the ground. At every meal the same program is gone through, and every day. As the season changes the drudgery becomes more keen. Its supplies are exhausted, and it is compelled to take its wing and emigrate to a new country. This is how birds live, and this is how birds are made. Life is a fierce effort, a supreme struggle—beek and limb, claw and wing, shape, strength—all down to the last detail are the expressions of their mode of life.

Human life is also a struggle, excepting that man is sometimes lured on by visions of glory instead of being goaded on by hunger. There is a prevalent conception in the world that there are some favored positions and vocations, where success is attained without the treadmill. But it is probably true that there is just as much prosaic uninviting detail forced into the lives of those who are supposed to be living the charmed life as there is in your life.

Not many people who stand before a great painting and admire the genius, skill and brain of the artist ever appreciate the years of privation and poverty that lay back of the artist's success. Everything valuable is costly. The dimensions of our soul life are determined by the ideal to which they are set. The quantity and quality of personality depend upon the scale after which we copy. If the ideal be complete, the life will be rich and full, and if the dominating aim of our life be unsteady, without a clear-cut purpose and definite goal, the life will be as shapeless as a jellyfish.

The growth of every character has three stages —past, present and future. The past is the field of wisdom; the present the sphere of endeavor; the future the home of hope.

It is possible to live in the past and speak words of wisdom, but to miss the everlasting joy of transforming present realities into living facts. It is possible to live in the present and forget the storage of wisdom which men have left for our encouragement. And the life whose eyes are fastened only on the future, while hands hang listlessly at one's side, may stand sometimes upon the transfiguration mount, but he has left the animals at the base of the mountain in whose presence there is little safety of those for whom we are responsible. No man can be content with the past or present. We are continually stringing our harps for the winds of tomorrow. Today is the child of yesterday, and tomorrow is the legacy of today. All future character depends upon our use of the present.

Someone asked, "Where was Italy three centuries ago?" and the answer was, "Under the cap of Dante." For, in the dream of the patriotic

poet, there throbbed the picture of broken and bleeding Italy, marching forth in triumph to its present progress—liberty and union.

Protestantism three centuries ago was under the cowl of a Wittenberg monk, but his brain was the soil in which grew the seed which we call Zwingli, Melancthon, Knox and Wesley.

Where was education three centuries ago but in the brain of Comenius, and his life was the soil in which Rosseau, Froebel and Pestalozzi sprouted. And the education of tomorrow is all about us, in the lives of those whom too often we fail to appreciate.

Once a year, just after the great throng of young people have heard again the call of the college or the high school, and before they cross its threshold, I like to devote one service to the consideration of some phases which may be suggestive to them in the new field of effort to which they are called.

There are four words around which there gathers wisdow for those who have ears to hear. These words are cultivate, accumulate, habitate and dedicate.

The first of these words is CULTIVATE.

We are the offspring of cultivation. Naturalists have often pointed out to us the fact that while man is a ruler among the animals, he is also the most helpless creature at birth, and requires the greatest cultivation to reach anything like maturity. The chick begins to peek as soon as it leaves the shell; the duckling takes to water at once; birds fly in a few weeks after they are hatched, while in three months a pup can execute untold damage on his mistress' parlor carpet, but the babe's life hangs by a thread for many days, and infinite care is needed, in the absence of favorable conditions its life is in danger, and with favorable conditions many months must pass before the child can even stumble around. The family, the church, the State and the school then begin to contribute to its education.

The force of this command to cultivate our life gains very much emphasis when we remember that upon the use of our present there is an inevitableness in the result. When Charles Dickens first published the "Old Curiosity Shop" he was flooded with letters from all parts of England, from people who had read the story in installments in the magazines, pleading with him not to take the life of Little Nell. But he yielded to the inevitable, and when at last he reached the story of her health, all night he walked the streets of London, sad at heart, as though he had lost a real friend, but he said: "I had to do it; the preceding events demanded it," and upon the use of your present opportunity some of you will write a silly novel; some will write a fearful tragedy, and some a psalm full of sweetness and love for all mankind.

The Divine command to every individual is to cultivate his field. We are to make the most of ourselves and the place that God has given us.

History has given us few better illustrations of the art of cultivation than the story of Michel Angelo. Old, blind, feeble, feeling his way into the art gallery, and with uplifted face, putting his fingers and hands over the torso of Phidias, the Cardinal heard him say: "Great is this marble, greater still the hand that carved it, greatest of all the God who fashioned the sculptor; I still learn, I still learn."

Think of the man who is willing to toil in the drudgery of painting the ceiling of the Sistine Chapel with the picture of his "Last Judgement" and the story of the "Creation" for seven years, until the muscles and cords of his neck had become so rigid that he could not look down without bending his whole body. Think of the man who carried his bread with him to the scaffold and worked while he ate, so that he might not lose any time. For days his clothes remained on his body, and his eyes refused sleep. By the side of his bed he kept a block of marble, and the chisel and mallet lay on his table, and the call of a new idea was never disobeyed. When his three score years and ten were passed he still said, "I still learn, I still learn." Such a man could not help but immortalize himself in art.

May I use another illustration? You have heard of the life of Robert Louis Stevenson. He was counted by some the most remarkable English writer of his generation, but the work of his pen was the smallest part of his life. If the stories he wrote and the poems with which he enriched the world are at last forgotten, what the man was will live, for his character was one of the most unselfish and lovable in human beings. At 20 years of age he had spent most of his time trying to tinker up his physical frame, and then found himself a nervous wreck; at 30 years of age, just able to sit up in bed and mould clay figures', after which he rapped his fingers upon the board and called for his writing materials, and gave form

to those remarkable stories that were the delight of our earlier life. Fighting his poverty, lowliness, ill-health, he rose above his troubles, and to the very last remained the child of laughter and sunshine. Men said of him that he was always eager to help his fellows, always ready to take the second place. With great difficulty offended, and expecting to die for 20 years, he "dug out the kernal of life and threw away the husks." Each morning seemed to him like a golden gift from God of which he must make the most.

It ought to be the mission of your life to cultivate facts. Concrete facts are terribly dynamic. Intelligent knowledge is the rudder of zeal. Without facts men sail and sail, and arrive nowhere. A multitude of people have accumulated something like facts—forty-second cousins to the real thing, but so often have failed to get *the* facts. See to it that you recognize the tremendous power of facts in your education, but remember that facts, after all, are but means to the end. The mission of the teacher and the school is to enable people to think. It is to draw inferences from certain facts, it is to arrive at certain conclusions. Cultivate not only the power of fact and thinking, but also the power of expression. So often in human life we find that the most intelligent people must secure men to carry their intelligence to market. Now, the marks of a cultivated life are modesty, humility, delicacy of organization, and executive tact; just the things that are usually crushed in the struggle for life, thus the real forces of life are often obscured. The great lawyer is not always at the head of the bar; the man who speaks twenty languages is not the successful teacher; Samuel Johnson was not skilled enough in literary bargains to protect his self-interest; the walking encyclopaedia is usually used as a reference library. This is because men have not cultivated themselves symmetrically. See to it that while your brains are cultivated that your brawn is not forgotten. When you decline Latin, see that you do not decline exercise. Let the cultivation of your life give you the fullest use of all your powers. It has been too long supposed that a man goes to school so that they may pump wisdom enough into him to enable him to ladle out at retail all the remainder of his days, provided he does not ladle too fast. But the most important part of education is what you get for yourself. The term education has been abused, but nevertheless it stands for a great idea. All that the school can do for you will be but a small matter compared with what you must do for yourself.

The second duty in the struggle of life is to *accumulate*.

I exhort you to amass a fortune in your field; even on its lowest basis—that of money—it is the duty of a man to make his expenditure less than his income. The tendency in our age is toward extravagance. Debt has ruined a multitude of people. What is there that is more pathetic than that picture in the life of old Walter Scott, when Lockhart wheeled him into the summer house and saw that he was killing himself by the work which he felt he must do because of his debts. One day he suddenly said: "This will never do, I must get down to work," and when he tried, he could not hold the pen or dictate a word, but sat still, with the tears streaming down his fine old face—a victim of debt.

Someone has said, If you should call the roll of a score of the most cultivated children of this generation, you would find that eight out of twenty, including a great orator, a novelist, two jurors, a wit and two statesmen were all caught in the meshes of debt. These sons of genius fell on death, like birds caught in the thicket that tore off their bright plumage in the struggle to escape the thorns, only to fall, beating their bleeding wings against the ground. There is a happy land between the acrtic zone of poverty and the tropic zone of plenty where men spend less than they earn, and thus accumulate. But remember that money is not the only wealth. Anything that makes for weal is wealth. Mr. Pearson, who has given his millions for colleges, would be poor if he had nothing but his money. Mr. Peary, in the Arctic regions, with bones and metals would be richer than the Standard Oil magnate with his checkbook. Money is easily destroyed. A gold piece will wear away. The banknote will disappear at the touch of a match. Every man can accumulate better goods than these. Knowledge is one of the things that does not perish. Health is a blessing that has no value in money. There is a certain atmosphere—an indefinable quality—sometimes called culture, that comes from a course in college that is invaluable in life. Think of the people that never accumulate. They had a single talent given them at the beginning and they wrapped it in a napkin. It was a small napkin. There the people who began small grow smaller and finally evaporate. They are like one of the

rivulets that we meet in our summer travels, trickling, like a slender thread, their way among the barren stones, but every thirsty noonday sun makes them disappear. They trickle, trickle, trickle until death dries them up, and no one misses them. They were a blessing to no one; they refreshed no living thing. Earth is not any poorer for losing them, and heaven not much richer for gaining them. How much different is the life that grows richer through accumulation. Their life is like a river. It has its birth under some mossy rock in the mountain. It steers its modest path over the rough roads, laughing, leaping with its own silvery music. Sometimes it disappears for a while, but when you find it again it is like a broad river, beating against its banks, swelling up and kissing the boughs that bend over it, and spreading out and spreading out until on its placid bosom the ships laden with merchandise ride at anchor, and in its azure depths is mirrored the flags of every nation. Let your life grow rich in the volume of every grace, and as you sail the great ocean of life see to it that you mirror back the glory of Christ's gracious handiwork, as you bear up human hopes and contribute your share to the enrichment of the world.

The third step in the struggle of life is to have a goal of *Habitation*. Every man makes his own world. We may make out of the materials a mansion. Multitudes of people that have beautiful houses live in baskets, because they live subordinate to physicial pleasures and public wants. With everything about them, there are people who fail to use what they have in the right way.

In a Western city a church was about to erect a building, and the question arose as to what material should be used. Some would have granite of New England; others wanted the green rock of Pennsylvania, and some others were in favor of the limestone and brick. An old farmer said: Let us build our church out of the very bowlders which lie on the surface of the prairies all about us. The novelty of the suggestion brought everybody to its support. The church was built, and then it was discovered that from these homely stones an edifice of sumptuous beauty had been reared. In them were all the glories of the rainbow, and this house, constructed at little cost and from material unnoticed, is the admiration of all who see it. Though each be unattractive in itself, yet grouped together in the tones of precious stones, the materials of a glorious life lie all around us.

From the lumber that is taken from the same mill one man constructs a hovel, another builds a mansion. The only difference between the mortar and bricks that are used in the warehouse and the mortar and bricks that are used in a palace is the dream of the architect. The difficulties which hinder one man become stepping-stones to another man. Marsden says, "Some people, like the bee, seem to gather honey from every flower; while others, like the spider, carry only poison away." One person finds happiness everywhere, and on every occasion carrying his own holiday with him; another always appears to be returning from a funeral. One sees beauty and harmony wherever he looks; his very tears afford him visions of rainbows as the sunbeams of hope fall upon them. Another is blind to beauty; the lens of his eyes seem to be smoked glass, draping the whole world in mourning. One sees in the matchless rose nothing but rose water for sore eyes; another reads in its blending colors and its wonderful fragrance the "thoughts of God."

One student finds just what he is looking for in the college to which he goes—the best teachers, the finest equipment, the most glorious history—and he becomes an enthusiastic alumnus at the end of his course; but another finds in every college to which he goes that the equipment is limited, the teachers poor, and the college devoid of any true spirit. Our subjective attitude has much to do in what the school will mean to us.

The earth beneath our feet is largely composed of four substances: Clay, sand, soot and water. Give it the right conditions, and the clay will become porcelain and furnish the finest kind of a background for a fine painting; give the sand the right conditions, and it will become hard and white and will take into itself the blue rays of the sunlight and become a sapphire; the soot, under proper conditions, is transformed into a diamond, and the water in the summertime is a dew drop and in the winter a star.

The humblest and lowliest life with the right spirit may build a mansion with a window that opens out on to the radiant clouds; a mansion, with a door to the street that swings out, that the tenderness and sympathy of our lives may flow out to a saddened world, and swing in with a hospitality that may be found for the stranger, the desti-

tute in the fireside and table of good cheer which we give to the world.

And, finally, it is your duty to *Dedicate* your life. In the 18th Chapter of Jeremiah there is a remarkable description of Jeremiah's one day going into the valley where the potter was at work moulding clay on a wheel. And as he stood by and watched the skillful manipulation of the worker he had no idea what pattern was in the designer's mind, though probably it was one of the noblest conceptions and designed for some royal or special purpose. And so by those rapid revolutions of the wheel, the ideal began to take shape. Suddenly the designer took the clay from the wheel with an exclamation of disappointment. The design was spoiled. Because the teacher was wanting in skill? No; but because the clay refused to take on the shape which he had designed. The work was therefore marred on the wheel, and he was compelled to make out of the clay some inferior vessel to that which he had intended. It might have served a noble purpose in a royal household, or even in the temple service, but it was now fashioned into some coarser form, for use in a business house.

The parable is not without its lesson, and so, if we dedicate our lives to Him completely, the ideal will reveal itself in our experience. It is a fatal mistake to put off the matter of sharing that with which we are intrusted until some future time. If you ever expect to bless the world, begin now. Whatever wisdom you have is a trust for the sake of ignorance; all wealth is a trust for the sake of poverty. You are simply stewards of strength for the sake of those who are weak; every college boy and girl, and, indeed, every high-school boy and girl is a privileged life. They are selected people in the providence of God, and to none more than these should there come a great conviction that it is to be their privilege and duty to build the booths in the desert of life for the sake of the world-smitten ones, and to dig the springs in the oasis for the sake of life's thirsty ones; to bear the burdens of those whom they meet, and in that very dedication they shall build for themselves a palace of beauty which shall be filled with prosperity and God's peace.

Take a dish of water cold,
  A little leaven of prayer,
A little bit of morning glow,
  Dissolved in the morning air.

Add to your meals some merriment,
  A thought of kith and kin,
And for your prime ingredient
  A plenty of work thrown in.

Then spice it all with an essence of love,
  And a little whiff of play;
Let the wise old Book and a glance above
  Complete the well-made day.

Cultivate—Accumulate—Habitate—and Dedicate your life in the struggle for existence.

A VISIT TO THE MAYO CLINIC AT ROCHESTER, MINN.

By Randolph Winslow.

The city of Rochester is situated in Minnesota, 350 miles northwest of Chicago. Its population is about 8000. It is the county-seat of Olmsted county, Minnesota, which is said to be the richest agricultural county in the United States. It is quite a handsome town, with attractive residences and large stores. Its chief importance, however, is due to the fact that here is located St. Mary's Hospital, at which the Drs. Mayo do their surgical work. St. Mary's Hospital is a fine institution, capable of accommodating 225 patients. The surgical work that is done in this institution by the Drs. Mayo and their assistants is so stupendous in amount and excellent in skill that physicians and surgeons from all over the United States are in constant attendance upon this clinic, as well as many eminent surgeons from Europe and other parts of the world. My first visit to this clinic was made in the winter of 1904, upon which visit I was accompanied by Dr. J. Mason Hundley. Our reception was so cordial, and the work we were able to see was so great and of such variety, that I have desired many times to repeat the visit. The opportunity, however, did not appear to present itself until the first week of September of this year. Leaving Baltimore upon September 4 in company with Dr. Robert P. Bay, superintendent of the University Hospital, we took our journey toward the Northwest, and reached our destination 36 hours later. We found a large company of physicians in attendance on the clinic, exceeding 50 daily during the time of our stay. As has been said, these physicians were, many of them, prominent men from

various parts of the United States, and several were surgeons from European countries. We were received with great cordiality, and every opportunity was afforded us both to see the operations and to inspect the hospital. From 20 to 30 operations are performed daily, beginning at 8 o'clock in the morning and ending usually at 1 or half-past 1 in the afternoon. These operations are performed usually by Drs. William J. and Charles H. Mayo, who, with Dr. E. S. Judd, are the regular operators at the hospital; but many operations are also performed by Drs. Beckman and Henderson, who are members of the surgical staff. Dr. William J. Mayo confines himself chiefly to work upon the abdominal organs, and he is undoubtedly the greatest abdominal surgeon in the world. Dr. Charles H. Mayo devotes his attention especially to general surgery, though he is equally at home in any of the other lines of surgical work. He is by far the most experienced, as well as most skillful, operator upon goitre in this country, and his work on this line of cases is truly phenomenal. He is equally at home, however, in operating upon the eye or upon the abdominal viscera, or, in fact, in almost any line of surgical work. Dr. Judd, the younger member of this aggregation, and who is related by marriage to the Drs. Mayo, also does an enormous work of a great variety. When some of these men are absent the work is taken up by other members of the staff. Their work is characterized by great celerity as well as by exceptional skill, and the visitors at the clinic go from one room to another in quick succession, though it is absolutely impossible for one person to see all the operations that are done. I was especially interested in the goitre work by Dr. Charles H. Mayo, and in four days was able to see 10 or 11 cases of goitre operated on of both the simple and exophthalmic varieties. It was astonishing to note with what ease and safety operations upon these difficult cases were performed. By the subcapsular method all danger of injuring the parathyroid glands and the laryngeal nerves was avoided. His operations for cancer of the breast are characterized by thoroughness and speed, so that operations which in the hands of many require several hours for their performance are usually accomplished by him in about 30 minutes. As has been said, Dr. William J. Mayo confines his work chiefly to abdominal surgery. He is operating almost daily upon the stomach and intestines, as well as upon the other abdominal organs. We were fortunate in being able to see performed many serious operations upon the digestive organs, as well as upon most of the other organs situated within the abdominal cavity. During our visit he performed four partial gastrectomies, in which a large portion of the stomach was removed for cancer. We also saw several gastroenterostomies, several resections of the caecum and sigmoid colon, and were permitted to see the cases subsequently in the hospital, and found all of them doing entirely satisfactorily. We saw three nephrectomies for various causes, one being for hypernephroma, which is ordinarily regarded as a rare form of kidney tumor, but which Dr. Mayo says is the most frequent malignant neoplasm of these organs. A number of gall-bladder operations were performed, as well as operations upon the urinary bladder, the uterus, ovaries and tubes, to say nothing of the vast lot of less serious work that was performed daily. The work at this clinic is reduced to an absolute system. The visitors are summoned to the different operating-rooms by the ringing of an electric bell, which indicates by the number of strokes the room in which the operation is about to be begun, and visitors are not expected to enter any of the operating-rooms until the proper signal has been given; but as operations are going on in three rooms at the same time, it is impossible for each person to view all of the work, and he must see that which is most instructive to him. The administration of the anaesthetic is done entirely by women nurses, and there is very little struggling or evidence of difficulty to be seen during the administration in comparison with most clinics. The assistants are few in number, there rarely being more than two in addition to the anaesthetist and the nurse. The operating-rooms are well equipped, but are not elaborate, and the excellence of the results attained is due not so much to the superiority of the equipment as to the skill of the operators and the excellence of the organization. St. Mary's Hospital is conducted by an order of Catholic Sisters, and was started just 20 years ago as a small institution by Dr. William W. Mayo, the father of the Drs. William J. and Charles H. Mayo, who is still living and hale at the age of 91 years. By successive additions and alterations the hospital now is practically a fireproof structure of handsome design, with, as has been said, accommodations for 225 patients. It

is a marvel to everyone how a work of such moment can be done in a hospital of no greater capacity than this. Patients are gotten out with remarkable quickness, so that but few of them remain in the hospital longer than two weeks, even after a most serious operation. There is, however, a constantly increasing list of patients waiting to be operated upon when accommodations shall be found for them in the hospital. For example, we were told that 25 cases of goitre were on the waiting list of Dr. Charles H. Mayo and 15 cases of cancer of the breast were also waiting an opportunity for operation.

The Mayo offices are not at St. Mary's Hospital, but are located in the Masonic Hall in the center of the town, and here a great throng of patients are examined and treated by Drs. Graham and Plummer and others, and nine-tenths of these cases are not surgical and do not come under the care of the Drs. Mayo at all. At half-past 2 in the afternoon the Drs. Mayo go to their offices and examine such cases as are referred to them to determine whether they shall enter the hospital to be operated on or not. Most of these cases are ambulatory in character and do not require immediate attention, and they are obliged to take their turn for admission to the hospital. A number of specialists are associated with the Drs. Mayo in their work at their offices, but most of the patients requiring anaesthesia are operated on by the regular operators at the hospital. Probably from 150 to 200 patients daily are seen by the members of the staff at the offices. Not only is the medical and surgical work thoroughly organized, but the pathological department is also conducted upon the same broad plans as the other work of the hospital. Dr. L. B. Wilson is the pathologist in charge of the pathological department, and he is assisted in his work by Dr. W. C. MacCarty and Dr. Margaret Smith. One or other of these persons is always within reach during the operating hours, and specimens removed from patients are at once submitted to an examination. If there is doubt as to the nature of a tumor or growth, a frozen section is made and a report is returned within five minutes. In their museum are 6000 appendices which have been removed within the last four years; 1200 goitres are likewise preserved, as well as specimens of all the organs and structures of the body. The Drs. Mayo have built a beautiful library and assembly hall for the use of themselves and associates, and on every Wednesday night there is a meeting of the members of the staff at this hall, to which, at times, visiting physicians are likewise invited. Here reports and discussions are held in order that the latest contributions to medical literature may be communicated to all. Whilst many physicians visit Rochester for the purpose of attending the clinics, when the clinics are over there is but little diversion of any kind to be enjoyed; consequently a surgeons' club has been formed, which meets daily at 3 o'clock in the afternoon for the purpose of discussing and further explaining the cases that have been under observation during the day. All visiting physicians are not only eligible for membership in this surgeons' club, but are urged to join it, the admission fee being $2. In this manner the irksomeness of the time is, in a measure, overcome. At the east end of Rochester is a large and well-conducted State Hospital for the Insane, which is not visited by many physicians, however. The chief hotel is the Cook House, which is a very excellent hostelry at a very moderate cost, and it is full to overflowing all the time. In addition to this, there has recently been erected the Kahler House, which is especially intended for convalescent patients and their friends, but to which visiting physicians are admitted when there is room for them. This is a smaller hotel than the Cook House, and is conducted upon a more elaborate scale, and naturally is much more expensive. The Chute is also a hotel or sanatorium for convalescent patients who cannot afford to pay the charges of the more expensive hotels. There are a number of other hotels in the town, of the excellence of which I am unable to speak, and accommodations can also be had in numerous private houses for those who prefer a more quiet location. Visiting physicians usually stay about a week, so that on each Monday morning a practically new company assembles, and on Saturday there is a general hegira from the town. Enough, however, remain to initiate the newcomers into the routine of the clinic. It is with great pleasure that I am able to announce officially that Dr. Charles H. Mayo will deliver two lectures upon the surgery of the thyroid gland at the University of Maryland in the middle of November, which I am sure will be interesting and instructive to all who may be able to attend them.

SUBACUTE INFLAMMATION OF THE ANTEROLATERAL TRACTS OF THE SPINAL CORD AS AN UNUSUAL COMPLICATION OF LA-GRIPPE.

By Joseph W. Hooper, M.D.,

Assistant Resident Physician, University Hospital.

Patient white; male; age 39; farmer; single; entered hospital giving the following history:

One year and a half ago patient had a severe attack of grippe, with its usual train of symptoms, high temperature, persistent headache, photophobia, general pain and soreness over the whole body, etc. He refused to go to bed, and before he had entirely recovered from his attack he went out. The weather at that time was cold and damp. Thinking to protect himself, he wore heavy felt boots; he noticed in a short time that these were uncomfortably hot; he changed them for a pair of light shoes; his feet and legs almost immediately became extremely cold.

Ten days after this he noticed that his legs seemed heavy, and it was with difficulty that he was able to raise them; this was more marked in left lower extremity than in the right. There was no pain, but a peculiar drawing sensation. This condition gradually became more pronounced.

Six months ago the patient was given a very hot bath. While in the tub the drawing became very severe, and he was almost unable to get out of the tub and back to his room.

At time of entrance patient complained of a burning and tingling sensation in the calves and ankles, numbness in his feet and difficulty in raising them from the ground; inability to walk in the dark, and a tendency to trip over his feet.

He also complained of a sense of constriction about two inches above the umbilicus. This was especially noted when patient bent forward. There was a constant sense of fullness in the stomach.

He tired very easily in his lower extremities, especially from his knees down.

At times patient had difficulty in voiding his urine; at other time he was unable to control his urine, and frequently soiled himself. The same was true as regards the evacuation of his bowel.

Three days prior to entrance patient jumped a distance of 10 feet; since then he has had a tight feeling, a sense of constriction over his sacrum. Appetite good; no pulmonary symptoms; no cardiac symptoms; no urinary or gastrointestinal symptoms, save those mentioned. Nothing of importance obtained from past or family history.

Physical examination showed a very well-developed white man, five feet 10 and one-half inches tall, bony framework (massive), muscles of good tone, skin in excellent condition; expression good; mentality and memory good; ears low set; teeth in fair condition; palate normal; heart and lungs normal.

Upper Extremities.—Motor functions normal; sensory functions normal; coordination normal; no atrophy.

Reflexes.—Triceps, biceps, periosteal and radial slightly increased on both sides.

Trunk and lower extremities abdominal muscles normal.

Extensions normal; flexions of thighs and legs weak; flexions and extensions of feet normal.

Sensory Functions.—From a line running around the body on a level with the umbilicus in front and the twelfth dorsal vertebra behind, to the knees, tactile sensation is obtained; below the knees it is absolutely lost.

From a line running around the body on a level with the anterior superior spines of the ilium to a point a little above the knees, higher in back than in front, sensation of pains is obtained, patient being unable to distinguish sharp from dull; below the knees it is absolutely lost.

From a line running around the body on a level with the umbilicus in front and the twelfth dorsal vertebra behind to a line five inches above the knees, temperature sense is obtained; below this line it is lost.

Where sensation can be preceived, muscular sense is normal.

Co-ordination in lower extremities poor; Roneberg's sign present; no atrophies.

Reflexes.—Abdominal deficient; tremasteric present, but delayed; patellar reflexes exaggerated; Babinski and Gordon's reflex present on both sides.

Tendo achilles exaggerated on both sides; tendency to ankle clonus; abnormal movements. At times there are contractions of various groups of muscles of the thigh and leg on either side. The contractures occur at irregular intervals, sometimes on the anterior and at others on the posterior surface. Blood and urinary findings normal; tuberculine reaction negative; spinal puncture and X-ray examination negative.

From the history and examination of the patient

we came to the conclusion that we were dealing with a condition that was either directly or indirectly the result of his attack of la-grippe.

The conditions that suggested themselves were multiple neuritis, tabes dorsales, syringomyelia, inflammatory changes in the spinal cord, tubercular pachymeningitis spinalis and syphilitic mennigo-myelitis.

We excluded multiple neuritis by the presence of increased deep reflexes, bowel and bladder disturbances; sensory disturbances on the trunk; syringomyelia by the absence of dissociation of sensation; trophic disturbances, history of the case, etc. Tabes dorsalis was excluded by the history of the case, absence of pulpillary disturbances and cranial nerve involvement, presence of increased reflexes and distribution of the sensory disturbances.

Tubercular pachymeningitis was excluded by the absence of the tuberculin reaction, the radiating pains and negative X-ray plates. Syphilitic meningomyelitis was excluded by the absence of any history of syphilitic infection and the absence of improvement on thorough antisyphilitic treatment.

We made the diagnosis of an inflammatory condition of the anteriolateral portions of the spinal cord infections in character for the following reasons: The condition occurred immediately following or in the course of an existing infectious disease, "La-Grippe," the gradual progression of the disease, the character and distribution of the sensory disturbances, the presence of bowel and bladder disturbances, of increased deep reflexes, of the typical Babinski and Gordon reflexes, the distribution and type of motor disturbances, the absence of atrophies and trophic disturbances and the irregular spasmodic contractures of various muscle groups.

The following treatment was recommended: Patient was freely purged; kept quiet in bed for two weeks; counter irritation by means of Spanish fly blisters applied over lower dorsal segments of the cord, and then when these places were thoroughly healed a light plaster-of-Paris jacket was applied to the patient while in extension, this being done to immobilize the back. He was also given internally Fowler's solution.

Certain changes have occurred in the spinal cord which cannot be rectified, but we can at least hope for some improvement and to stop the further progress of the disease.

THE PROFESSORS OF SURGERY IN THE UNIVERSITY OF MARYLAND.

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

No. 2.—William Gibson, M.D., LL.D.

The second incumbent of the chair of surgery was Dr. William Gibson, who was elected to this position on the 6th of April, 1812, when he was but 24 years of age. He continued to hold this chair until 1819, when he was called to a similar position in the University of Pennsylvania. Dr. William Gibson was born in Baltimore on March 14, 1788. He was educated at St. John's and Princeton colleges, and began the study of medicine at the University of Pennsylvania, but in 1806 he went abroad and entered the University of Edinburgh, and graduated there with the degree of M.D. in 1809. Subsequently he went to London and became a pupil of Sir Charles Bell, who was at that time a famous surgeon in the English metropolis. Soon thereafter he went to the seat of war in Spain and was present at the battle of Corunna. He returned to Baltimore in 1810, and at once took a prominent professional position here. In 1812 he was made professor of surgery in the medical school, and during the summer of that year he performed the first ligation of the common iliac artery on record. This was upon a man who had received a gunshot wound of the abdomen during the riots in Baltimore. In addition to the injury to the artery, the intestines were wounded in two places, and each opening was closed with a ligature. The patient died on the fifteenth day from ulceration of the artery and peritonitis, but this operation established his reputation in surgery. In 1814 he again went to Europe, and, being in the vicinity, was present at the battle of Waterloo, where he was slightly wounded. He was also a surgeon to the Maryland troops during the War of 1812. Whilst clinical facilities were limited during the time that he was professor of surgery in the University of Maryland, he occasionally performed operations in the presence of his classes at the Maryland Hospital on Broadway, which occupied the same location that is now held by the Johns Hopkins Hospital. He was also surgeon to the Almshouse, which was located about the present situation of Howard and Madison streets, and at times held

clinics at this institution. He was said to have been an attractive teacher, with a distinct and melodious voice, and expressed himself in graceful and well-chosen language. He was a rapid and dexterous operator, and possessed great mechanical ingenuity. He was likewise a skillful worker in wax, a fine artist and a musician of no small ability. He was also a highly educated man with a predilection for the classics. In 1819 he left Baltimore for Philadelphia, where he had been called as professor of surgery in the University of Pennsylvania. He continued to fill this chair until 1854. He died in Savannah, Ga., on March 2, 1868, aged 80 years. He was twice married, having several children by each wife. One of his sons, named Charles Bell Gibson, after his friend, Sir Charles Bell, the London surgeon, became a distinguished surgeon and professor in the Washington University of Baltimore, now merged with the College of Physicians and Surgeons, and the Medical College of Virginia at Richmond. Dr. Gibson was represented to have been of robust frame, broad shoulders, full face and ruddy complexion. After his removal to Philadelphia he became one of the most eminent surgeons in the United States, and performed many operations of great magnitude and importance. Amongst these was Caesarean section performed twice on the same woman, saving both mother and children. He also extracted a ball from General Scott that he received at the battle of Lundy's Lane during the War of 1812. He was the author of an elaborate treatise on surgery, in two volumes, which went through eight or nine editions. According to Professor Gross, he was an accomplished lecturer, lucid writer and able surgeon. The removal of Professor Gibson to Philadelphia was a great loss both to the University of Maryland and the city of Baltimore. The University of Edinburgh, in appreciation of his distinguished career, conferred on him the honorary degree of LL.D.

THE ETIOLOGY OF CHOREA.

By H. D. McCarty, M.D., of Baltimore.

In discussing the etiology of Chorea Minor, I beg to present the following observations, which have been drawn from numerous sources, and though I have been unable to find anything conclusive, the studies of the various writers, showing the striking similarity of the hypotheses to which they hold, strongly suggest the malady to be of an infectious nature.

To those who are interested in the views of early observers as to the cause of chorea, I would refer them to an article in *The Johns Hopkins Bulletin*, 1901, by Dr. H. M. Thomas, entitled "Chorea With Embolism of the Central Artery of the Retina," giving a short review of the embolic theory.

Dr. Thomas quotes Kirkes in this article, as follows: By the mere circulation of morbic blood through the nerve centres partly, also by temporary obstruction in the minute capillaries occasioned by fibrinous particles arrested therein, the irritation leading to the development of chorea or other analogous phenomena may be accounted for. In this same article it is stated Roger, in France, 1886, went so far as to state that rheumatism, chorea and endocarditis were all manifestations of the same poison.

I have myself often thought whether chorea was to be regarded as a disease or as a symptom of an infectious condition, in which endocarditis and metastic arthritis played an essentially important part.

Working in Dr. Thomas' clinic at the Johns Hopkins Dispensary, I had the opportunity of observing quite a few cases of chorea minor, and one could not help be impressed with the constancy with which that malady was associated with the sore throat, arthritis and endocarditis. The temperature of the chorea patient was reguarly taken and its absence rarely noted.

Dr. Thayer, in an analysis of 808 cases published in *A. M. A. Journal*, 1906, showed in 689 of these cases that 25.4 per cent. had evidences of cardiac involvement.

Wyss—*Jahrbuch fur Kinderheilkunde*, Berlin, 1908—studied 51 cases of chorea minor at Zurich (1874-1907). In 41, that is 80.4 per cent., a certain connection between chorea and acute articular rheumatism or endocarditis was evident, either in the patients themselves or in their parents, brothers or sister. Rheumatism had preceded chorea in 16 of the 51 children, that is in 31.3 per cent., while rheumatism followed the chorea later in 40 per cent. of the 35 children, whose later history was known. Endocarditis was observed at the time or later in 54.3 per cent. of the 51 chronic children. He calls chorea, rheumatism and endocarditis the three acts of a single drama.

Duckworth—*B. M. J.*, June 23, 1906—reiterates his belief that chorea is a variety of rheumatism, which more particularly involves the brain. He says that the evidence in favor of the rheumatic nature of chorea is stronger, if possible, from the clinical than from the bacteriological side. Chorea is more frequently seen in families prone to rheumatism. It may precede by months or years an onset of rheumatic fever, or it may supervene during an attack. His statistics show a family or personal history in 85 per cent. of cases of chorea.

Cotton—"Textbook on Disease of Children," 1906—says: "The mode of onset, the self-limitated character of the attack, the accompanying anemia, the subsequent heart lesions and its tendency to recurrence, all stamped chorea as a phase of rheumatism with more than a suggestion of microbic etiology."

In "Pfaundler and Schlossman's Textbook on Disease of Children," 1908, Wollenberg writes: "A definite relation has been established between chorea minor, rheumatism and endocarditis. This connection is not observed in other forms of chorea, and strongly suggests that chorea is to be regarded as an infectious disease."

A few authors (Laufenauer, Tribuolet, Bechterew and others) always refer it an infectious cause, and look upon the other factors as exciting causes. Positive evidence of micro-organisms in the brain of choreics have been found in but few cases (results of Richter, Berkley, Dana, H. Meyer, Pianese). Pianese found a diplococcus and a diplobacillus, cultures of which produced experimental chorea.

Holt says: "The relation of chorea to rheumatism is most striking, and of late has attracted much attention. The results of different writers are somewhat at variance. Some have found evidences of rheumatism in but a small proportion of the cases (5.10 per cent.), while others have placed the statistics as high as 50 or 60 per cent. It is rather striking." Holt says: "The statistics of neurologists, almost without exception, have given a very much smaller percenage of rheumaism in chorea cases than those taken from children's clinics and hospitals." He says the question hinges largely upon what is to be considered as evidence of rheumatism in a child. If cases of acute articular inflammation only, then the number will be small; if subacute cases, with joint swelling, are included, the proportion will be considerably larger, while if we admit cases of acute endocarditis without articular symptoms, and those of articular pain and joint stiffness without swelling, the proportion will be much increased. He believes there is a close connection between chorea and rheumatic diathesis as manifested by symptoms above noted and accompanied by a family history of rheumatism. There seems then to be a large group of cases which may be classed distinctly as rheumatic chorea. There are, however, many others in which no such element can be found.

The analysis of 146 cases by Crandall, quoted by holt, showed the following result:—

Definite history of rheumatism, 63 cases.

Rheumatism occurred before chorea, 41 cases.

Rheumatism and chorea coincident, 13 cases.

Rheumatism subsequent to chorea, 9 cases, usually within three months. In one-third of cases attacks of rheumatism occurred during or subsequent to the chorea, as well as before it. Then previous rheumatism was evident in 37 per cent., concurrent in 24 per cent., subsequent in 15 per cent. Excluding cases mentioned twice and all those in which there was only a history of growing pains, there was evidence of articular rheumatism in 56.7 per cent. Many of these patients, Crandall states, have now been under observation for several years, and it has been interesting to see, as time has passed, how evidences of rheumatic diathesis have multiplied, the longer the cases have been observed.

Holt says: "If cases of endocarditis without articular symptoms were included, as I think they might fairly be, it would raise the proportion of rheumatic cases still higher. The great proportion of cardiac murmurs persisting after chorea, if not all of them, should, I believe, be classed as rheumatism, even if no articular symptoms have been present."

Guthrie Rankin—*B. M. J.*, 1908—says: "The peculiar and intimate association which exists between chorea, cardiac disease and rheumatism is well recognized, but the relationship has not yet been established."

Morley Flecher, quoted by Rankin, concludes from a study of 580 cases that chorea is a manifestation of rheumatic fever, but that many other causes may co-operate in the production of the disease. Rankin further states when rheumatism attacks children it tends to exert its influence more on the heart and pericardium than on the joints,

so that if care be not taken to seek for evidence of endocarditis of pericarditis the true association of chorea with the rheumatic poison may be overlooked. In fatal cases one or more of the cardiac valves are found diseased, and the interdependence of chorea and rheumatism in the vast majority of the cases is now generally admitted. There seems little doubt that both depend upon the same or closely allied micro-organisms.

Legay of Paris published statistics in 1897 which went to show that the disease occurs for the most part in children with a neurotic heredity who have recently suffered from an infectious disorder. In the majority of the instances the infection was rheumatic, but he quoted many cases in which chorea was apparently directly due to the poisons of measles, scarlet fever, influenza and tuberculosis.

Sturges has pointed out that it is not an uncommon sequelae of whooping-cough.

Nearly all writers agree as to the age the disease is most common. It rarely occurs under 5 years. Fifty per cent. of all cases are met with between 5 and 10 years. Another 30 per cent. between 10 and 15 years. It attacks girls three times more frequently than boys, and after the second decade the per centum of females increases.

Holt gives in 146 cases 6 under 5 years, 72 between 5 and 9 years, 68 between 10 and 14 years.

Carpenter, in the *B. M. J.*, 1906, reports a case of rheumatism with chorea in a child three and a half years old, with hyperpyrexia. Mitral murmur was present and numerous subcutaneous nodules the size of small beans. Optic neuritis later developed, the child dying about 8 weeks after the onset.

Wollenberg points out that girls are more often attacked by severe forms.

As to season, it is more prevalent in the cold, wet months. Holt says "it may be seen at all seasons, but is more frequent in the spring." Of 717 cases studied by Lewis of Philadelphia the largest number began in March. The next largest in May. In Holt's cases May stood first. Certain families are specially predisposed; mostly those in which a rheumatic and neurotic inheritance are combined.

Rankin states a general nervous disposition is noted in 20.30 per cent of cases. He further states the relation between neuropathia and chorea is by no means clear. It is not to be denied that febrile diseases or chronic nutritional disturbances, which lower the resistance of the entire organism, and therefore of the nervous system, might produce a certain predisposition to the intoxication or infection which manifests itself as chorea.

By some writers reflex irritation, such as that produced by dentition, intestinal worms, errors of refraction, etc., is held responsible for choreic manifestations.

It must be borne in mind that much confusion has existed in the minds of many as to what is to be called chorea, and no doubt that irregular movements arising from above-mentioned irritation might be tics pure and simple. I would direct your attention to differential points cited by Meige and Feindal in their book on "Tics and Their Treatment."

Children who have suffered from one attack are liable to a recurrence. Rankin states the proximate cause is probably a micro-organism similar to that of rheumatism, the toxins of which are responsible for the nervous manifestations with which we are familiar; but even if this hypothesis be ultimately confirmed, it must be admitted that the direct excitant of an attack is in many instances some form of mental disturbance. In children fright is the most acute of all emotional states, but it is conceivable that excessive joy or sorrow may act in a similar detrimental way on those suitably predisposed. It is not impossible that the emotional excitant may be responsible for two varieties of the disease, according as the child harbors the rheumatic micro-organism or not; that in one instance, and that the more frequent, it may be rheumatic manifestation and in the other neurotic.

Gowers states that 25 per cent. of all cases are due to fright, and that in his experience the interval between the fright and the development of muscular movements rarely exceeds a week.

Sturges (and many observers agree with him) regards the disease as a functional expression of nerve irritability induced by numerous extraneous causes, and urges in favor of this view the remarkable limitation of the disease to the period of childhood, its preference for females, and its onset at a time when the requirements of growth and education are exciting a strong demand upon the resisting power of the sensori-motor ganglia.

Finally, there are not wanting advocates of the microbic origin of the disease, and it has been

found that the diplococcus, isloated by Poynton and Payne from the joints of patients with acute rheumatism, is capable of producing, when injected into rabits, not only arthritis, but endocarditis; but in some instances also a form of chorea. Sections of the cerebral cortex of an animal thus rendered choreic have revealed masses of diplococci in connection with the small arterioles. The probable entry of the organisms through the delicate mucous membrane of the naso-pharynx has been suggested as a possible explanation of how infection may occur, and there can be no doubt that the disease occurs in association with several types of sore throat.

M. de Ponthiere ("Annales de Medecine et Chirurgie Infantiles," Paris): After ten years' observations, comments on the rapid and permanent cures obtained by removal of tonsils and adenoids which are chronically affected, his conclusions are that chorea is generally the outcome of an auto-intoxication produced by swallowing septic material secreted by the lymphoid organs of the naso-pharynx. The naso-pharyngeal infection is nearly always rheumatic. The pharynx is nearly always responsible for the cardiac and arthritic manifestations of rheumatism which follow on septic sore throats. The author adduces the analogy of other local and general symptoms which are common to adenoid and choreic patients, such as deficient nasal respiration, disturbed nights, night terrors, dyspnea, muscular and intellectual disabilities, difficulty in concentrating the attention, alterations in the character, digestive disturbance, distaste for food, especially in the morning; lymphatism, and the stupid aspect of the choreic, which is the same as the adenoid facies. The examination of the naso-pharynx is thus of the greatest importance in cases of chorea, as the origin of the neurosis will be often discovered there.

The influence on chorea of suitable treatment of the nose and throat will convince the most skeptical, he says, of the unmistakable connection between them.

In connection with the possibility of chorea being due to a toxin, I would like to call attention to the experiments by Phisalix on sparrows. He found that the bee sting produced in them true choreiform movements, in which the muscles of the feet, head, wings and eyes were affected.

The association of chorea with pregnancy is by no means rare. It seems to occur in those who have had chorea or some manifestation of rheumatism previously.

In the *Deutsche Medizinische Wochenschrift*, Berlin and Leipsic, 1906, Martin reports a case of chorea with pregnancy. During the first pregnancy the patient had acute articular rheumatism. The subsequent pregnancies were attended with chorea, which reappeared with each succeeding pregnancy with increased intensity.

From the facts that chorea occurs more frequently during that season of the year when the mucous membranes are mostly to be infected, occurring in children at that period of life when they are most liable to throat trouble; the disease being many times associated with conditions known to be infectious; the febrile course of the disease; all strongly point toward chorea being an infectious malady.

CORRESPONDENCE

A TRIP TO RICHMOND, THE CAPITAL OF THE COMMONWEALTH OF VIRGINIA AND THE SECOND CAPITAL OF THE CONFEDERACY, PETERSBURG AND WILLIAMSBURG. THE SECOND CAPITAL OF VIRGINIA.

EDITOR OF BULLETIN.

Embarking on the good steamer Atlanta of the York River Line I left Baltimore, Saturday, July 31, 1909, at 5 P. M., and sailed down that magnificent body of water, the Chesapeake, reaching West Point, Virginia, the next morning at 8 A. M., thence entrained on the Southern Railroad and reached my destination at 9.30 A. M. The country between the York and the James Rivers, is flat, sandy and not well cultivated, but pleasing to the eye; only here and there did I see fields of corn, nor is it apparently thickly populated. The greater part of the train trip was passed through scrub woods of pine, oak, holly, etc. The journey took us over the Pamunkey, a broad, shallow, picturesque river and a feeder of the York. Richmond, founded in 1737 by Colonel William Byrd and incorporated as a town (1742), is at the head of tidewater and navigation. Situated on the north bank of the James on a series of terraced hills, it contains much of historic value to interest the stranger. The panorama, from the Seven Hills, of the Valley and of the Falls of the James

is superb and pleasing. Here John Smith and a companion landed after they had left their followers at Jamestown Island—the first capital of Virginia—the Falls of the James barring further progress to their journey.

During the Revolutionary War La Fayette had his headquarters for a time in the city of Richmond, the building, an old stone house, being still in an excellent state of preservation and located in the eastern section or old part of the city. It is claimed that Washington visited the Count in this building, whence it is called Washington's headquarters. Tarlton and Arnold during the Revolution raided as far inland as Richmond.

But it is the stirring and eventful part Richmond played in the Civil War that chiefly concerns the visitor. Here many of the Confederate soldiers of the Civil War were mustered into service; here the last scenes of that great contest culminated in the disaster and ruin that left large sections of the city in ashes; here today one sees everywhere the results of the energy which has effaced the signs of those troublous times; and the enterprises which have tripled the population, which is now rated as 125,000, against 37,910 in 1860.

The White House of the Confederacy, the war time residence of the Confederate President, Jefferson Davis, at the corner of Twelfth and Clay streets, is now a Confederate Museum and Memorial Building. The house, an old fashioned residence, was built in 1819, and bought by the city of Richmond for the use of the Confederate Government. During the Federal occupation it was used by General Witzel as headquarters, but with the revocation of martial law, the city of Richmond established its first public school in it; for which purpose it was employed until 1890, when it was turned over to the Confederate Memorial Literary Society, who have entirely renovated the building and restored it to its erstwhile appearance. With but one or two exceptions no relic has been purchased. Each Confederate State is represented by a Room, set apart as a memorial to her sons and their deeds. The relics and books are invaluable and a fitting testimonial to the valor and manhood of our Southland. In order to meet running expenses an admission of 25 cents is charged.

St. Paul's Church, at the corner of Grace and Ninth streets, is of interest, for here it was President Davis while at worship received news from Lee that the city must be evacuated. In this building are memorial windows erected to the memory of Lee and Davis. Lee's old headquarters are on Franklin street between Seventh and Eighth. The famous Libby Prison has been removed to Chicago and a factory erected on its site.

In Hollywood Cemetery, so called from the abundant and luxuriant growth of holly, at the western edge of the city are buried Davis, Pickett, Stuart, Presidents Monroe, Tyler and Madison and many other distinguished personages. Here is to be seen a massive pyramid of stone erected to the memory of the Confederate dead and monuments upon the burial sites of those just mentioned. We of the South should feel an especial gratification in the beautiful and quiet resting place of President Davis.

Capitol Square enclosing ten acres of ground is a beautiful spot, adorned with trees, flowers, fountains, and historic buildings. Here upon an elevation, is located the Capitol, plain in character, with walls of stuccoed bricks and a portico with massive columns, and designed after the Pantheon. Within its walls the Confederate Congress met. In the Rotunda is Houdon's celebrated Statue of George Washington. It houses the offices of the Governor, and a room in which there is an exhibit of the products of Virginia. In this building is also to be seen the speaker's chair from the Colonial House of Burgesses.

Besides the Capitol this square contains within its enclosure, the Governor's Mansion, colonial in style, the Library Building, recently completed, Washington, Clay, Smith, Jackson and Hunter McGuire Monuments, and the old Bell House. On Franklin street are to be seen monuments to Lee, Davis and J. E. B. Stuart. Many other objects and points of interest abound. Old St. John's Church, where Patrick Henry delivered his famous speech "Give me liberty or give me death" is open to strangers free of charge. If you are looking for historical places and incidents, go to Richmond. Here you will get your surfeit.

From a material standpoint Richmond is also interesting to the traveler; nearly forty-five years ago it was almost annihilated by fire. Today, are to be seen no traces of this great conflagration, factories, stores, public buildings not only cover the destroyed area, but extend miles in other directions. It is above all a clean city, and is away ahead of Baltimore in this respect. Its streets are paved either with asphalt or belgium blocks, occasionally with vitrified bricks. No cobblestones

are to be seen. Much to her credit there is no surface drainage. Baltimore could indeed take a lesson. The number of two-story houses are striking. There are some modern residences in the western part of the town. On Grace street, the aristocratic neighborhood, the houses are no two alike, colonial in structure mostly, with some veranda, and surrounded with a little grass or flower plot. Even the less pretentious houses have some ground in front of them and I did not see in the residential quarter during my stay a solid row of houses such as we have in Baltimore.

Crepe Myrtle, in bloom, and magnolia trees are to be seen on every side. The holly and fig tree flourish here as nowhere else. Hotel accommodations are good and reasonable. For visitors bent on sight seeing the Murphy or the Richmond Hotel are centrally located, their rates moderate and service excellent. The street car service is unexcelled, and reaches all points of interest, as well as surrounding suburbs. Transfers are freely issued and a transfer is given on a transfer. Richmond is however poorly lighted.

Of no doubt of more importance to you, as medical men, will be a short account of the medical colleges of Richmond, of which there are two, the Medical College of Virginia, the older, and the University College of Medicine, the younger of the two, and an offshoot of the former. Both embrace departments of medicine, dentistry and pharmacy, and both have a student enrollment of approximately 350.

The Medical College of Virginia, is located at the corner of Marshall and College streets. It was founded in the year 1838. At first this institution was a part of Hampden-Sidney College, but in 1854 it was chartered as a separate institution. It has a continuity of existence as its doors were not closed during the war between the states. The main building, modeled after the Egyptian style of architecture, is large and imposing. In it there are a number of classrooms. The laboratories are in another building, the former Old Dominion Hospital, the clinical instruction now being given in Memorial Hospital, an imposing structure, corner Twelfth and Broad streets. This hospital is built externally of terra cotta bricks. Its interior is tastefully arranged and furnished, its amphitheatre roomy and its walls partially tiled, the floor of terrazza. There are several other operating rooms, an excellent and up-to-date X-ray and electro therapeutic outfit. This hospital holds about 150 patients when full. As the State of Virginia and the City of Richmond make no provision for charity cases this hospital as well as Virginia Hospital connected with the University College of Medicine, are forced to curtail their running expenses and during the summer months are obliged to close their public wards. The wards are large, well ventilated and comfortable, and the private rooms which range in price from 7 to as high as 25 dollars per week are very attractive. The kitchen is on the top floor. Here I saw a slight operation by Dr. Horsley, a rising young surgeon of Richmond. The technique was excellent and all concerned seemed to be familiar with their part.

Coming back to the school the laboratories were fairly well equipped and ought to be able to do good work. A small library attached to this institution was housed in a large room, but as far as I know had no regular librarian. The dispensary was in the basement of the laboratory building. Considering that the school is not endowed, it should and in all probability is doing good work. I was very much impressed with its appearance and its potentialities. Mr. McCauley, the secretary of the Board was very attentive and courteously showed me through the buildings. He also explained to me the inner workings of his office and I assure you it was very business like. As far as possible he keeps a card index system of the address of each and every graduate. The grades are kept on the loose leaf ledger system and at the end of the fourth year, these are bound into a volume and filed away.

The University College of Medicine, founded in 1893, is housed on Clay and Twelfth streets. It was chartered as a joint stock company, but in 1904 another charter was conferred upon it, changing it from a private enterprise to an institution governed by an independent board of trustees. The buildings are large and occupy approximately half of a city block. The lecture rooms are commodious and the laboratories should apparently be able to render a good account of themselves. In this institution there was a Pasteur department. On the whole the appearance of the buildings did not strike me as favorably as those of the Medical College of Virginia. The Virginia Hospital, the clinical part of the institution was housed in two old colonial houses which had had their dividing partition knocked out, and enlarged as occasion demanded by several additions. The private rooms

appeared cosy and comfortable, the wards well kept, and the whole institution was in shipshape order. Here I saw a case of pellagra, and a colored woman recovering from a decompression operation. Both the Hospital and the University, however, had the air as if they were suffering from hampered finances.

PETERSBURG.

Petersburg is to the south of Richmond and conveniently reached either by the 14th or 7th street trolley for Manchester, where a change is made to the Petersburg line. The price of the trip is 40 cents each way. This town is situated on the banks of the Appamatox River. It is hilly. More space intervenes between the houses, but it is smaller than Richmond. The remains of the Crater, filled with trees, whose trunks in some instances are as large as a man's body, is to be seen. Old Blandford church near the Crater and in which are buried some of the victims of this engagement, is well worth inspecting; memorial tablets and windows being numerous. One of the windows is to the North Carolina troops, of whom more than 45,000 were killed during the war, with Lee's epitaph, "God bless North Carolina." The court house is a quaint old building. There were some very pretty and pretentious homes in this city.

WILLIAMSBURG.

Williamsburg the second colonial capital, is indeed a very interesting, instructive and entertaining spot. Situated on the peninsula between the York and James Rivers, it is reached from Richmond by the Chesapeake and Ohio Railroad, the ticket being $1.20 each way. It is about seven miles from Jamestown Island. In 1699, owing to the burning of the State House at Jamestown, the seat of government was removed to Williamsburg. The remains of Martha Washington's kitchen, namely the chimney, is still standing. The old Court House is an object of interest. William and Mary College, founded in 1693, is located in this town. The main building was fired by the Federals and almost completely destroyed. As far as possible in the rebuilding the old walls and bricks were used. The buildings of this institution are very quaint. Many distinguished men have been students at William and Mary, among whom may be mentioned Patrick Henry, Chief Justice Marshall, President Monroe, General Winfield Scott. It was in this town that the immortal George Washington first met his future wife, Mrs. Custis.

The foundation of the House of Burgesses is still to be traced, and a tablet marks the spot. The crowning glory of Williamsburg, however, is Bruton Church, the oldest Episcopal Church in continuous service in America. Here five presidents have worshipped: Washington, Jefferson, Madison, Monroe and Tyler. During colonial times the Governor and members of the House of Burgesses worshipped here. King Edward recently presented a bible to the church and President Roosevelt has given an electra on which the bible is to rest. The church is constructed on the plan of a letter H and is finished with a mahogany effect. The pews are dedicated to the worthies of the past, many of whom are buried under the floors. The janitor, William, a colored man, was very polite. He had at his finger's end the life history of each and every celebrity whose life had happened to be interlinked with that of the church. Washington's step-children are interred in the churchyard. In this town is also to be seen Washington's headquarters, the Old Powder Horn, wherein the ammunition was stored—it has now been converted into a Colonial Museum—and the Eastern State Hospital, the first insane hospital in the United States.

NATHAN WINSLOW.

TO THE EDITOR:

Why not a "Booster Club" or "Praise Your Brother Club" in the American Medical Association, with no dues or other requirements except that each member pledge himself never to speak unkindly or in criticism of a brother physician to the laity, except that physician be also present. Let us renew our vows and wear buttons to show that we mean to keep them.

If such a condition could be brought about we would be held in much greater esteem by our patients and neighbors. Whenever a physician is condemned, maligned or criticised by another physician, the ill-will engendered in the minds of the laity is not against the one physician, but the class; individuals are forgotten and the profession is remembered as a whole. If I tell every one I meet that Dr. Pill is a rank physician; knows nothing of medicine and will stoop to any mean practice, the laity soon forget that Dr. Pill is a "poor

doctor" and retain the impression that we are all "poor doctors" ready to stoop to anything.

Let's stop it; raise the standard. Can we get together at St. Louis and organize a club?

Yours for "no knocking,"

W. T. Wootton, M. D.,

Hot Springs, Ark.

The above from the Journal A. M. A. of August 7th, '09.

Will you agitate such a scheme to the end that we may create a better general impression upon the laity, restore confidence in our profession and take away the foundation for so many pathies, religeo-cures, etc.?

Very sincerely yours,

W. T. Wootton.

The Bulletin will be glad to receive members to Dr. Wootton's club.

ITEMS

Doctor Joshua W. Hering has been renominated as State Comptroller by the Democratic Organization of Maryland. Doctor Hering was a member of the class of 1855, and is a resident of Westminster, Maryland.

Doctor W. M. Pearce is spending his summer vacation at Atlantic City with his family.

Doctor John R. Winslow, Clinical Professor of Diseases of Nose and Throat, has returned from his summer vacation, which was spent at Cape May, New Jersey.

Doctor C. W. McElfresh, Clinical Professor of Medicine, has returned from his summer vacation, which embraced a trip to West Virginia and Pittsburg. In the latter city he saw some good work in cranial surgery.

Doctor Randolph Winslow, Professor of surgery, has left on a trip to the Mayo brothers in Rochester, Minnesota. He will be accompanied by Doctor Robert Bay, superintendent of the University Hospital.

Doctor and Mrs. Nathan Winslow have returned from Richmond, where they spent some time visiting points of historic interest. An account of the trip appears elsewhere in this number.

Doctor J. W. Bird, ex-resident physician to the University Hospital, is located at Sandy Spring, Montgomery county, Maryland. It was the pleasure of one of the editors to pay him a flying trip and he appears to be making a success of practice.

Doctor Walter Scott Carswell is stopping at the Chalfonte, Atlantic City.

Doctor and Mrs. Norman F. Hill have returned to Baltimore from a visit to their son, at Buffalo, New York, and will move to their apartments at the Walbert, September 1, 1909.

Doctor John C. Keaton, class of 1907, of Quincy, Florida, is the guest of Doctor J. L. Valentini, 1302 N. Broadway, Baltimore.

Doctor John A. Tompkins has returned to his home after a fortnight's stay at Bar Harbor, where Mrs. Tompkins is spending the summer.

Doctor Ariste W. Giampietro, class of 1907, of Baltimore, has been appointed physiologist in the Bureau of Plant Industry, at Washington.

Doctor Gianpietro is 28 years of age and prominent among the Italian contingent of the city. He is the organizer and head of the Republican Organization known as "Young Italy." He lives at 3007 Baker street, Walbrook, Baltimore. The appointment came as the result of the successful passing of a civil service examination.

We are more than glad to announce to the many friends of Doctor Lawrence Kolb, class of 1908, and an ex-resident of the University Hospital, where he did exceptionally good work, that he has passed the examination for the Public Health and Marine Hospital Service, and has received a commission as assistant surgeon. He has been ordered to report to medical officer in charge at Baltimore for assignment to duty.

Doctor and Mrs. J. Frank Crouch have left Bretton Woods, New Hampshire, and will spend several weeks at Lenox, Massachusetts.

Doctor and Mrs. Francis Janney, of Catonsville, Maryland, are at Atlantic City.

Doctor Fitz Randolph Winslow, class of 1906, spent his vacation at Luray Cave, Virginia.

Dr. William K. White, class of 1902, who was operated on recently at the University Hospital, has made a good recovery and left the institution. Doctor White is one of the most popular of the younger physicians connected with the University Hospital and the news of his recovery will be welcomed by his many friends.

Doctor A. G. Pole and family, of Baltimore, have left for Atlantic City, where they will be the guests of the Chalfonte for several weeks.

Doctor William H. Smith, class of 1900, ex-resident physician and surgeon to the University Hospital, and formerly superintendent of the Hebrew and Bay View Hospitals, broke his leg recently while engaged in a game of baseball between the internes and the dispensary staff.

Doctors J. N. Reik and T. Chew Worthington have sailed for Europe, where they will attend the meetings of the International Medical Congress at Budapest in September. After visiting Switzerland and France they will return home about October 1, 1909.

Doctor Frank Martin, who is travelling in Europe, expects to return to his home the early part of October.

Doctor Frank Lynn, class of 1907, will sail for Europe during the latter part of September, where he will devote his time to pathological and surgical investigation.

Doctor M. J. McKinnon, class of 1853, a venerable and prominent physician of York, Pennsylvania, besides one of the oldest living alumni of the University of Maryland, is critically ill at his home in York.

The following of our alumni are members of the Board of Trustees of the Medical and Chirurgical Faculty of Maryland:

S. C. Chew.
J. W. Hunnrichouse.
L. McLane Tiffany.
Wilmer Brinton.
G. Lane Taneyhill, Sr.
D. E. Stone.

Doctor J. McPherson Scott, of Hagerstown, secretary and treasurer of the Maryland State Board of Medical Examiners, has made public the names of those candidates who were successful in the June examination. Those of our alumni who passed:

Clarence I. Benson.
N. I. Broadwater.
William S. Campbell.
Clarence B. Collins.
Arthur L. Fehsenfeldt.
Harry B. Gantt, Jr.
Richard H. Gantt.
Joseph W. Hooper.
Joseph I. Kemler.
Howard Kerns.
Samuel H. Long.
James P. Magraw.
William E. Martin.
John J. McGarrell.
James B. Parramore.
Samuel J. Price.
Wilmer H. Priest.
William G. Queen.
Harry A. Rutledge.
Reed A. Shankwiler.
Claude C. Smink.
Maurice I. Stein.
Charles F. Strosnider.
Alfred C. Trull.
Frederick C. Warring.

The following of our alumni have been president of the Medical and Chirurgical Faculty: Doctors—

Ennalls Martin, class of 1818.
Robert Moore, class of 1819.
Robert Goldsborough, class of 1820.
Maxwell McDowell, class of 1818.
Joel Hopkins, class of 1815.
Richard Spigg Steuart, class of 1822.
Peregrine Wroth, class of 1841.
William W. Handy, class of 1819.
Michael S. Baer, class of 1818.
John L. Yates, class of 1822.
John Fornerden, class of 1823.
Joshua I. Cohen, class of 1823.
George C. M. Roberts, class of 1826.
Nathan R. Smith, Professor of Surgery.
Charles H. Ohr, class of 1834.
Henry M. Wilson, class of 1850.
John M. Monmonier, class of 1834.
Christopher Johnston, class of 1844.

Samuel P. Smith, class of 1817.
Samuel C. Chew, class of 1858.
H. P. C. Wilson, class of 1851.
Frank Donaldson, class of 1846.
Richard McSherry, class of 1880.
Thomas S. Latimer, class of 1861.
George W. Miltenberger, class of 1840.
I. Edmondson Atkinson, class of 1865.
John Morris, class of 1826.
Thomas A. Ashby, class of 1873.
L. McLane Tiffany, class of 1868.
George H. Rohe, class of 1873.
J. Edwin Michael, class of 1873.
Samuel Theobald, class of 1867.
William T. Howard, Professor of Gynecology.
Eugene F. Cordell, class of 1868.
Samuel T. Earle, Jr., 1870.
Hiram Woods, class of 1882.
Charles O'Donovan, class of 1882.
G. Milton Linthicum, through St. John's College.

Doctor Preston Hundley, class of 1909, of Buckley, West Virginia, was successful before the West Virginia Board of Medical Examiners. As far as I could find out Doctor Hundley was the only graduate from our school participating in the examination.

Dr. Samuel Theobald, class of 1867, has been elected president of the American Ophthalmological Society. He is the first president of this society from the South. Dr. Theobald is a distinguished oculist in this city.

Dr. N. W. Hershner, class of 1906, recently moved from Stewartstown, Pa., to Mechanicsburg. He has succeeded well in his profession.

Dr. R. W. Fisher, former assistant Resident Physician to the University Hospital, is now practicing his profession with distinguished success in Morgantown, W. Va. Dr. Fisher writes to THE BULLETIN that he finds THE BULLETIN very interesting reading, and always enjoys reading the same, as it keeps one informed as to the whereabouts of old friends and classmates and of their progress.

Dr. Fisher has recently been elected President of the Monongalia County Medical Association of West Virginia.

THE BULLETIN wishes him success and many honors.

Dr. Edward V. Copeland of Round Hill, Va., who graduated from the medical department of the University of Maryland in 1905, sailed from New York for Europe on September 11, and will take post-graduate courses in London and Vienna.

Dr. J. Julius Richardson, class of 1889, of Washington, D. C., is accompanying President Taft upon his Western trip as medical adviser.

Drs. W. J. Blake of Benwood, Simon W. Hill of Switchback, Preston Hundley of Berkeley, all of the class of 1909, have successfully passed the Board of Medical Examiners of West Virginia.

Drs. H. O. Keik, J. N. Reik, W. T. Watson, J. S. Fulton and T. C. Worthington attended the International Congress of Medicine at Budapest.

Dr. John S. Fulton, Professor of State Medicine, has been appointed executive secretary of the International Congress on Hygiene.

Dr. W. H. Houston was chairman of the Dorchester County Republican Convention, held on August 31, 1909.

Among the delegates to the recent Republican State Convention were Drs. G. T. Simonson of Somerset county, W. H. Houston of Dorchester county, Luther Kemp and S. L. Bare of Carroll county, and H. B. Gantt of Anne Arundel county.

Drs. A. L. Wilkinson, Josiah S. Bowen, George H. Hocking and R. C. Massenburg delivered short addresses at the September meeting of the Baltimore County Medical Society, held in the rooms of the County Board of Health.

Dr. W. Cuthbert Lyon, class of 1907, of Forrest Park, Md., was a successful candidate at the recent examination held at Fort McHenry for appointment as army surgeon, with rank of first lieutenant in the Medical Reserve Corps. Dr. Lyon is a native of Newburgh, N.Y., and a graduate of the medical department of the University of Maryland. Dr. Lyon, after having served a year as interne at the University Hospital, went

abroad, where he pursued a course of advance study in Germany. THE BULLETIN extends to Dr. Lyon its warmest congratulations and wishes him much success.

Dr. T. B. Owings, class of 1852, the president of the Howard County Medical Society, presided at the regular September monthly meeting, held at Ellicott City, Md., September 6, 1909. Dr. Owings is a prominent practitioner of Ellicott City and the surrounding country. He has been engaged in the practice of his profession for more than fifty-five years, and is one of the best known physicians in that section of the country. Dr. Frank O. Miller, class of 1902, and John W. Hebb, Jr., class of 1901, also attended the meeting.

Dr. C. D. Marchant, class of 1897, read a paper before the meeting of the Tidewater Medical Society, held in Fredericksburg, September 19, 1909.

Dr. C. W. Vogel, past assistant surgeon, United States Public Health and Marine Hospital Service, was granted three days' leave of absence from August 23, 1909, under paragraph 189, Service Regulations.

Dr. A. M. Shipley delivered a lecture to the Caroline Medical Society at Denton, September 9, 1909, on "Abdominal Diagnosis."

Dr. A. D. McConachie, 805 North Charles street, has been elected professor of the Diseases of the Ear, Nose and Throat, in the Maryland Medical College. Dr. Josiah S. Bowen has been appointed an associate to the chair of Diseases of the Ear, Nose and Throat in the Maryland College.

Dr. W. S. Love, 836 West North avenue, has been made professor of Therapeutics in the Maryland Medical College.

Dr. Jose Hirsh was in charge of the Hebrew Hospital baby camp, which has been closed for the winter.

J. Lee McComas, M. D., one of the oldest members of the historic McComas family and former assistant surgeon in the United States Army, spent September 12, 1909, at the Eutaw House. Dr. McComas was born in Baltimore May 24, 1835. His family is closely related to Henry McComas, who was shot and killed at the Battle of North Point.

The doctor retired from active practice in 1902, when he fell and fractured his hip.

Dr. McComas has had a varied career since being graduated from the University of Maryland in 1858. He started to practice medicine at Berkeley Springs, W. Va., and in a short time went to Oakland, Md. For many years he has been the house physician at Deer Park Hotel. In 1861 he was appointed an assistant Army surgeon and had charge of the Government hospital at Oakland.

Dr. McComas was the attending physician at the bedside of Jefferson Davis when he was a United States Senator. He also attended Harrison when he was in the United States Senate, and is the proud possessor of a cup and saucer donated to him by Mrs. Harrison, with the name Caroline H. Harrison engraved on it.

Dr. McComas has traveled extensively, and usually resides in Mexico in the winter. He speaks several languages. His son, Dr. Henry W. McComas, of Oakland, took up his father's practice at his retirement. For many years Dr. McComas, senior, was a surgeon of the Baltimore and Ohio Railroad.

Since returning from his sojourn at Hot Springs, Va., the health of Dr. Charles A. Wells, Democratic candidate for the State Senate from Prince George's county, has improved to such an extent that all doubt concerning his acceptance of the nomination has been removed. Dr. Wells said he would accept October 1, at which time he will define his position on some of the leading issues of the campaign.

When seen at his home in Hyattsville Dr. Wells said he proposed to prosecute a vigorous campaign from early in October until election day.

Under the caption of Leading Men of Maryland the *Star* has this to say concerning Dr. Frank Martin, Clinical Professor of Surgery, University of Maryland: "Dr. Martin is one of the best known practitioners in the city, and stands among the prominent medical men of the country. He is prominent socially and is a member of the leading clubs." Above the preceding inscription

is a portrait of Dr. Martin. By honoring Dr. Martin the *Star* confers a signal honor upon the University of Maryland, and the THE BULLETIN is glad that the professors of our institution are held in such high repute by the daily papers and the people at large.

Dr. D. C. Absher writes Dr. Randolph Winslow: "I am enclosing a clipping from a July issue of our local paper and it will tell you the esteem in which the University of Maryland is held in this part of the country. I want to see the University of Maryland prosper and become a real State university, and a great one, too, and I hope that some day I may be able to help it do so. I am assistant in a small hospital here, North Wilkesboro, N. C. The notice is as follows: "Dr. D. C. Absher was in town this week and has decided to locate here (North Wilkesboro, N. C.) for the practice of medicine and will return next week. Dr. Absher has just completed a thorough course at the University of Maryland, one of the highest institutions of the country, and received license to practice from the State Board recently at Asheville. It is a pleasure to have Dr. Absher locate here, which is his old home town and among his friends, with a promising future."

Dr. Julian Mason Gillespie, class of 1909, of Virginia, has successfully met the entrance requirements of the Army Medical Examining Board, and has been ordered to report at the Army Medical School, Washington, for instruction.

Dr. W. Cole Davis, class of 1908, formerly resident physician at St. Joseph's Hospital, Baltimore, has successfully passed the Army Medical Examining Board, and has been commissioned a second lieutenant in the Medical Corps, United States Army. He has been ordered to report at the Army Medical School, Washington, District of Columbia.

Dr. Joseph Gichner is being congratulated upon the birth of a brand-new baby.

Dr. Felix Jenkins, class of 1849, 84 years of age, one of our oldest alumni and for more than fifty years a practitioner of medicine in Baltimore, is seriously ill at the home of his daughter, Mrs. Thomas W. Offutt, near Towson, Md. Dr. Jenkins is one of the oldest living representatives of his family. He fell upon the pavement on Cathedral street in 1907, in front of the Cathedral, and broke his hip. Since that time he has been in failing health, and several weeks ago, owing to general debility, was compelled to seek his bed. Small chances for his recovery are entertained. Dr. Jenkins retired from active practice about six years ago, since which he has been taking life quietly.

Dr. Fitz Randolph Winslow, class of 1906, has returned from Hinton, Va., where he has been engaged for the past nine months in the practice of his profession, and has located at 1900 Mt. Royal Terrace, his former residence.

Dr. and Mrs. Frank Martin have returned from a tour of Europe. They were abroad several months.

Dr. William T. Watson, of Baltimore, has returned from a four months' trip abroad.

Our alumni took a prominent part in the transactions of the semi-annual meeting of the Medical and Chirurgical Faculty, held at Braddock Heights September 15, 16 and 17. Dr. Randolph Winslow read a paper entitled "The Surgery of the Thyroid Gland"; Dr. N. M. Owensby, "The Almshouse Care of the Insane," and Dr. J. J. Carroll, "Why Does Opthalmia Neonatorum Continue to Cause So Much Blindness?"

Dr. Nathan Gorter, class of 1879, made a report on the Pure Food Act. Dr. T. Clyde Routson, class of 1899, president of the Frederick County Medical Association, with a few well-chosen words welcomed the visitors on behalf of his local society, emphasizing particularly the honor which the Frederick Medical Society esteemed it to be the hosts of the Faculty.

Those who attended the semi-annual meeting of the Medical and Chirurgical Faculty:

Baltimore—Drs. C. U. Smith, James J. Carroll, N. M. Owensby, Herbert Harlan, Randolph Winslow, Samuel T. Earle, John T. King.

Westminster—Drs. Charles R. Foutz, H. M. Fitzhugh.

Hagerstown—Drs. E. A. Wareham, J. W. Hunrickhouse, W. D. Campbell, E. L. Bowlus.

Montgomery County—Drs. J. E. Deets, W. L. Lewis, T. E. Darby, E. C. Etchison.

Crisfield—Dr. J. J. Somers.
Pikesville—Dr. H. Lewis Naylor.
Bryantown—Dr. L. C. Carrico.

Those who attended were treated to first-rate scientific contributions. The social side of the meeting was not neglected, there being several entertainments, but owing to the unsettled weather the proposed side trip to Antietam battlefield was foregone.

Dr. John Evans Mackall, class of 1908, of Elkton, Md., a former assistant resident gynecologist at the University Hospital, has received an appointment in the Rocky Mount Hospital, N. C., of the Atlantic Coast Line Railway.

Dr. Arthur Ralph Hunter, class of 1903, of South Carolina, has been presented by his wife, who was Miss Martha Cook, a former pupil nurse in the University Hospital, with a bouncing boy. This is Dr. and Mrs. Hunter's second child, the first also being a boy.

Dr. James M. Craighill, Clinical Professor of Medicine, has been elected chairman of the Section on Clinical Medicine and Surgery, Baltimore City Medical Society.

DEATHS

Dr. Francis Marion Slemons, class of 1860, for many years one of the foremost citizens of Wicomico county, died September 22, 1909, at the home of his son, Dr. Morris Slemons, in Baltimore. Dr. Slemons has been for 49 years a practicing physician of Salisbury, Md., and was one of the leading medical men in his section of the State. He was loved by the people for his many fine qualities, and he will be missed in Salisbury as perhaps no other man would. Dr. Slemons was born at Fruitland, then Forktown, in 1839. The house in which this event occurred is still standing. He studied medicine in the medical department of the University of Maryland, and was graduated from that institution in 1860. After receiving his diploma, he practiced medicine in Fruitland for a number of years, then removed to Salisbury, and formed a partnership with the late Dr. Stephen P. Dennis.

Since early summer Dr. Slemons has been in failing health; at that time he was stricken with paralysis, and with his wife, who is also a paralytic, was taken to Baltimore, June 1, 1909, to the home of his son, Dr. Morris Slemons, a graduate of the Johns Hopkins Medical School.

He gradually became weaker after his removal to Baltimore, and died without ever having rallied. Dr. Slemons was nominated for clerk of the Circuit Court by the Democrats in 1885, after the memorable fight in the convention between the late Stephen P. Toadvine and Lafayette Humphreys. He was not a candidate, but was offered the nomination and accepted. He was elected, and filled the office creditably for six years. He was at the time of his death president of the Salisbury Building, Loan and Banking Association, which organization he helped, to form in company with the late William B. Tilghman and Ebenezer L. Wailes. Dr. Slemons was a ruling elder in the Wicomico Presbyterian Church. He leaves a widow and two sons, Dr. Morris Slemons of Baltimore and John Slemons of New York.

Dr. William S. Cockrell, class of 1879, died at his home near Harper's Ferry, W. Va., August 27, 1909, in the 66th year of his age.

Dr. Ernest E. Adelsburger, class of 1902, 30 years of age, of 414 N. Carrollton avenue, died Friday, September 17, 1909, at his home.

Dr. Adelsburger was a graduate of the University of Maryland, class of 1902, and has been practicing medicine since that time in Baltimore. He is survived by four brothers and three sisters.

Dr. James A. Shackelford, class of 1873, of Greenville, Miss., died July 19, 1909, at Carrollton, Miss.

Dr. Richard B. C. Lamb, class of 1904, of Yslita, Texas, died in the Providence Hospital, El Paso, Texas, June 22, 1909, of typhoid fever, aged 26.

Dr. John Woolf Burton, class of 1865, committed suicide by hanging at his home in High Point, N. C., June 30, 1909, aged 65.

Dr. Byron Clarke, class of 1881, died at Washington, Pa., August 5, 1909, of diabetes, aged 72. He was formerly professor of X-ray medicine in the New York Eclectic Medical College.

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BALTIMORE AS AN EDUCATIONAL CENTER.

By T. A. Ashby, M.D.

The Bostonians claim that Boston is the "hub of the universe" and the "Athens of America." This claim is based upon the culture, refinement and high standard of citizenship of the people of that city. However just the claim may be, it is a well-known fact that Boston stands among the leading cities of this country as a leader in all educational enterprises and civic exploits. As a home of the largest and most richly endowed university in this country, with magnificent hospitals and charitable institutions, with large public and private libraries and art galleries, with enterprising publishing houses, Boston undoubtedly possesses every establishment for the promotion of education and culture among her people. Her poets, historians, essayists, scientists and statesmen have taken rank among the leaders of thought and investigation in America. The people of Boston, therefore, have a right to take just pride in the high standard of culture which prevails in that community. When we consider the means by which these results have been reached it will be found that the people of Boston and of Massachusetts have been most liberal in their contribution to the endowment of their educational institutions and to the promotion of the best results which can be achieved by the liberal expenditure of money on education, charity, art and science.

Harvard University is a lasting monument to the liberality of the people of Massachusetts, whilst the splendid hospitals and charitable institutions in Boston bear testimony to the liberality of that city and State. Two factors have contributed to the claim which Boston makes as the "Athens of America"—first, her liberal expenditure of money upon her educational institutions, and, second, the industry, talent and enterprise of her people in fostering literary and scientific pursuit.

Comparisons are usually odious, but it is but just in making claims to consider conditions and environments. The advantages which Boston possessed in the past may be traced to conditions rather than environments. Certainly her location, climate and soil are not equal to those possessed by other communities. Her poverty in this direction has no doubt acted as a stimulus in promoting enterprises which have had less encouragement in more richly favored sections. Athens was only a small Grecian city, yet her contribution to art and literature is a marvel of the ancient world. It would seem that the genius of a people has reached its highest state of development under conditions where encouragement has been given by wealth and civic pride.

Institutions of learning must be subsidized by city, State or private benevolences, as they are less able to bear the struggle of poverty of all human establishments. To reach the highest standard of excellence and the largest development in research and instruction the best teachers and investigators are demanded, and all facilities for research must be supplied. Endowment or subsidy alone can give the equipment needed for the highest training of student bodies. The cost of education is constantly increasing, and tuition fees can no longer meet the requirements of our best educational institutions. The city, State and private aid must come to the relief of the teacher and scientific investigator if the best results are to be reached. This has been the secret of Boston's intellectual and educational supremacy. The people have liberally showered their wealth upon her institutions which seek to promote education, to relieve suffering and to elevate the standard of citizenship. The question now arises, Is it not time for the people of Baltimore to arouse to the importance of making this city the greatest educational center in this country? The location of this city in close proximity to the nation's capital, her genial climate, the social and liberal character of her people, all tend to show that Baltimore has all of the material advantages of a great center of learning. She

has educational institutions which, if properly encouraged, would provide facilities for the education of the largest bodies of students assembled from all sections of our country and from all parts of the civilized world. As far as can be ascertained, Baltimore is drawing annually to her educational institutions some 2500 students from wide sections of this country. Of this number over 1500 are drawn by our medical institutions. These students come from all States in the United States and from many foreign countries. Egypt, Assyria, Japan, China, Cuba, Porto Rico, Mexico and other foreign countries are represented in these student bodies.

The Johns Hopkins University, with its splendid record along the lines of scientific research, has extended the fame of Baltimore to all parts of the civilized world. This institution is destined to do a distinct class of work which will always reflect credit upon our city as the home of investigation and of intellectual and scientific progress. In addition to the Hopkins, there are a number of schools preparing both men and women for the practical duties of life in all the professions and avocations. It is to this class of institutions that the hand of friendship and of plenty should be extended by both city and State, since they are engaged in training the student along lines of work which make for education, culture and the highest citizenship. Education, in its broadest sense, is the preparation of the student for useful work, for high moral standards and for civic virtues. These are the qualities which go to make men, and these are the men who go to make cities and States. To attract the attention of the outside world to Baltimore as a center of education her institutions should be liberally subsidized and encouraged. They all need better facilities in the way of an educational plant providing laboratories, libraries and classrooms, better pay for teachers and instructors.

With an upward development of our institutions it is believed that the present student bodies now assembled in these various institutions could be doubled or quadrupled in the next five or ten years. In other words, with our educational institutions thoroughly organized and equipped for all classes of educational work of the highest standard it will be possible to draw to Baltimore a student body of some 10,000 students from all parts of the world. The presence of such a large body of young men and women seeking an education would have a material and moral value to this community which cannot be estimated in dollars and cents. Such a body of students would give to our city such a prestige as would soon establish for her the claim of being the "Athens of America." Why not try to wrest from Boston her honored claim as a leading center of learning in America and establish that claim for our own city, which already is so widely known as a city of monuments, as a home of art, of culture and of refinement? It is not too optimistic to make the claim that what has been done in New England for the promotion of the best interests of her people in education, charity and citizenship can be done in Maryland. All we need here is liberality, pride, love of learning and the high spirit of endeavor which has characterized the New England people.

It may be asked, How can the results here indicated be reached? The answer to this question will suggest both conditions and environments. Grant that Baltimore possesses both of these assets as her working capital, it is only necessary to use this capital in a productive way. Educational institutions, whilst, strictly speaking, they are not commercial enterprises, are so dependent upon administration and enterprise that success and usefulness only follow the wise use of these two agencies. An institution of learning must own a plant suitably adapted to all of its purposes. Its assembly-rooms, halls, laboratories and grounds must conform to the needs of its student body. Its teachers, instructors and demonstrators must be selected with due respect to their moral and intellectual equipment for the training of the individual student and of the student body. Both teacher and student must be fired with zeal and enthusiasm, and these faculties are only developed by co-operation.

With such a plant and equipment any institution of learning will grow, no matter how humble its beginning. A student body will follow the law of gravitation. It will always seek institutions of learning which live up to their promises and measure up to requirements. What is needed to make Baltimore a center of learning is for every educational institution in the city to get busy, go after the student and give him in training an equivalent for his outlay of money and mental work.

Nothing will draw students to our city faster and in larger numbers than this character of in-

tellectual honesty and industry. The education of the student must be considered from a commercial as well as from an ideal standpoint. The student is seeking knowledge primarily, and personal comfort, pleasure and sentiment as secondary claims. All of his needs enter into the development and training of his mind and character. His home life as a student, his associations, his ties and his personal comforts all should contribute to his mental growth and equipment. They should stimulate his pride and industry and enlarge his views of life and its responsibilities, as well as of its promises. Those institutions which recognize these various claims of its student body and work in harmony with them will receive full returns for the services rendered.

The life of a student in a large city is beset with embarrassments and temptations which must be met by the influence of the school over the mind of the student. This has been done in larger cities than Baltimore, which, perhaps, offers more ideal conditions as a center of education than any large city in America.

All of the institutions of learning in Baltimore are, with one or two exceptions, self-sustaining. In other words, they are dependent upon tuition fees for the conduct of their work.

In this age of large undertakings and of strenuous growth endowment seems absolutely necessary to the successful work of institutions which aim to attract large student bodies or to do a high order of work in advanced culture or scientific research. Without endowment an institution cannot rank among the great schools of the country. It cannot employ high-salaried teachers or do any extended work in research or original investigation. It does not follow, however, that such schools cannot do a useful or high order of work in lines of secondary education. Such schools can train lawyers, clergymen, teachers, engineers and physicians for practical and successful work in their respective professions. It will be recalled that less than 40 years ago the men who are now the leaders of thought and action in this country were almost to a man educated in schools which are now classed as secondary and which today are giving courses of instruction far in advance of that time. Secondary schools have advanced as rapidly as the largely endowed universities. They will continue to hold a large place in the educational curriculum. To rise to the front rank endowment is essential. This term endowment must be considered in a relative sense, since it occupies the same relation to education that capital does to railroads, manufacture or mercantile pursuits. The small merchant is as much in evidence as the department store, and in his small way is doing just as good work. The college, high school and private school have just as distinct a place in education as the endowed university. They are just as necessary to our social and economic life. They have as high, if not as distinguished, a mission in the educational world, and should stand for all that is best in training mind and character for private and civic duty. They will give character to communities quite as respectable as the larger institution if conducted on principles of correct thinking and right doing. With one large university liberally endowed, Baltimore has a large number of schools of the unendowed class which are drawing large classes of students to this city. These schools can be made the nucleus of her growth as a center of education. They possess advantages and possibilities which can be enlarged by the enterprise and broad spirit of their governing bodies. They have already done much for this city, which is only an indication of the larger growth of their student bodies under energetic and resolute action. In this determined purpose of drawing larger numbers of students to this city these schools should demand and receive every encouragement and aid possible from city, State and private liberality. There should be no hesitation in going before the public with the claim that generous aid extended to education in many forms and for recognized purposes is the highest test of civic pride and culture. The educational plant of a community is of greater value to that community, as a rule, than any other agency, not excepting a well-conducted press. When the wealth and intelligence of our citizenship is brought to realize that its culture, refinement and happiness is more largely promoted through the various educational agencies at work in their community than through its mercantile, manufacturing and commercial interests it will extend both financial aid and moral support to these agencies. It is, therefore, the first duty of every institution of learning in this city to keep its work in public view, to stand up for all that is best in our civic government, and to seek the aid of wealth and friendship in the more rapid growth of education and charity in our city.

THE PROFESSORS OF SURGERY IN THE UNIVERSITY OF MARYLAND.

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

No. 3.—Granville Sharp Pattison, M.D.

Prof. Granville Sharp Pattison was born near Glasgow, Scotland, probably in the year 1792. He is supposed to have received his medical education at the University of Glasgow. Early in life he was an assistant to Prof. Allan Burns, and succeeded him in the chair of anatomy, physiology and surgery at the Andersonian Institution of Glasgow. He was a favorite pupil of Professor Burns, and fell heir to his anatomical museum, as well as to his professorial chair. He came to America in the summer of 1819 and opened an anatomical school in Philadelphia; but, failing to receive an appointment in the University of Pennsylvania, and declining the chair of anatomy in the Transylvania University of Kentucky, he was offered the chair of surgery in the University of Maryland in 1820, which he accepted. He was at that time 28 years of age and had made no particular reputation as a surgeon; indeed, his predilections were for anatomy rather than for surgery, and, except for the brief period in which he remained in the University of Maryland as professor of surgery, his energies during the whole of his life were directed to the study and teaching of anatomy. He was a handsome young man, of a somewhat gay and restless disposition, and of a contentious and quarrelsome nature. He remained in the chair of surgery in the University of Maryland until 1826, when, owing to dissensions in the faculty and to the fact that the Legislature had repealed the charter of the university and had placed the government in the hands of a board of trustees instead of in the board of regents, in which it was originally vested, he resigned his chair and returned to London, where he was made professor of anatomy in the University of London. During his connection with the University of Maryland he made no great reputation as a surgeon, but is said to have exercised great influence in the faculty, and it is thought that the increase and prosperity of the medical school during that period was largely due to his energy and counsel. He brought with him from Scotland the museum of his master, Allan Burns, which he induced the university to purchase at a cost of $8000. This collection of anatomical and pathological specimens was one of the richest and most extensive in the United States at that time, and for many years continued to be the greatest attraction of the medical school. It was said to have numbered 1000 specimens, and even to this day some of the most valued and valuable attractions of the anatomical department were originally a portion of this collection. So valuable and so highly esteemed was this museum that a special building was erected for its housing, which became known subsequently as Practice Hall, but after various mutations, alterations and rebuilding is now the Gray Laboratory Building. Dr. Pattison returned to America in 1832, and was elected professor of anatomy in Jefferson Medical College in Philadelphia, which position he continued to fill until 1841, when he became professor of general descriptive and surgical anatomy in the recently founded medical department of the University of New York. He continued to occupy this chair until his death on November 12, 1851, after a short illness from obstruction of the common bile duct.

Professor Pattison was the author of the "Register and Library of Medical and Chirurgical Science." He edited, with notes, "Burns on the Surgical Anatomy of the Arteries of the Head and Neck," Masse's "Anatomical Atlas" and Cruveilhier's "Anatomy." He was one of the editors of the *American Medical Recorder*, and wrote a number of articles in the periodicals. He received the honorary degree of doctor of medicine late in life, and was held in high esteem as a teacher and lecturer in this country. He became involved in a controversy with Prof. Nathaniel Chapman of the University of Pennsylvania, which culminated in his sending to Dr. Chapman a challenge for a duel, which, however, Professor Chapman declined to accept, and in consequence of which dispute a hostile meeting was arranged some years later between Gen. Thomas Cadwallader of Philadelphia, who was Chapman's brother-in-law, and Professor Pattison. The duel took place in Delaware, and Cadwallader was severely wounded, the bullet entering his pistol arm near the wrist and lodging in the ulna, where it remained throughout his life, causing serious disability and impairment of health. Pattison escaped without injury by a narrow margin, as the bullet passed through the skirt of his coat near the waist.

REPORT OF A CASE OF CYST OF BRAIN.

By F. Rankin, M.D.,

Resident Surgeon University Hospital.

Owing to the comparative rarity of the condition and difficulty of diagnosis, perhaps a report of a case of cyst of the brain found in the left frontal lobe may be of interest.

A. P., white male, age 22 years, lawyer by profession, enters hospital July 30. Patient complains of a chain of symptoms extending over a period of three years, but which within the last six months have become so much more marked as not only to be noticeable to his associates, but to interfere with his work.

Motor aphasia, the most marked and distressing symptom of which he complains, has been a source of trouble only within the last half year, but during this time the patient's family have been aware of a decided change in the man's disposition and habits, he having apparently lost interest in things that formerly were his greatest pleasures and becoming gradually less energetic recently, showing no desire to do anything requiring any exertion, and more and more listless and inactive.

One distinctive feature of his condition, however, is the fact that he is never irritable nor has been known to complain.

At irregular intervals patient has suffered from violent headaches, the pain of which was diffuse over entire head, with no tendency to localize in any one place. The attacks were not accompanied by nausea or vomiting, but were occasionally preceded by any attack of vertigo. An examination of the eyes by an expert revealed no evidence of "choked disc."

PHYSICAL EXAMINATION.

Patient is small man, weighing 135 pounds and standing 5 feet 5 inches in height. Denies any loss of weight. Is well developed; muscle good; skin elastic; fair amount of subcutaneous fat.

Expression: Dull, listless, indifferent.

Eyes: Right pupil larger than left; reacts to light and accommodation, but rather sluggishly. Left pupil normal. Vision good in both. No "choked disc."

Ears: Low set.

Teeth: In excellent condition.

Palate: Arch normal.

Neck: No pulsations or glandular enlargement made out.

Thorax: Heart and lungs negative.

Cranial Nerves: Normal.

Motor Power: Normal.

Sensation: Normal, no areas of anesthesia or hyperesthesia being found over entire body.

Co-ordination: Good.

Patella Reflex: Exaggerated on both sides, slightly more so on right than on left.

Babinski: Present on right side.

Gordon Reflex: Present on right side.

Tendo Achilles Reflex: Slightly exaggerated on both sides, more so on right than on left.

Ankle Clonus: Present on both sides.

Abdominal Reflexes: Normal.

Mentality: Good.

Appetite: Good.

Bowels move regularly once a day.

No urinary or gastrointestinal symptoms.

Urinary Analysis: Color, straw; reactions, alkaline; sugar, negative; albumin, negative; specific gravity, 1015; sediment, scant; triple phosphates, amorphous phosphates, occasional hyaline cast, few leucocytes and epithelial cells.

BLOOD.

Leucocyte Count: 14,000.

Red-Cell Count: 6,488,000.

Hby. Count: 100 per cent.

Temperature: 98°.

Pulse: 68; full, strong, good volume and tension; equal on both sides.

Family History: Negative.

Past History: At age of eight years patient suffered from an attack of acute articular rheumatism, which was recovered from in short time and was followed by no sequelæ. Two years later, however, he developed Eydenhaur's chorea, which persisted for about six months and then cleared up, leaving the patient in good condition and without complications.

Specific History: Admits to gonorrhea six years ago, but since has felt no ill-effects. Negative to syphilis.

Habits: For past eight years patient has been a hard drinker and has lived a more or less dissolute life. Recently he claims to have given up the use of alcohol in any form. Is also an inveterate user of tobacco, using it mostly in cigarette form. Does not use coffee or tea.

Diagnosis: After careful examination of the

patient, as set forth above, the diagnosis of intracranial growth of the left frontal lobe was made for the following reasons: The gradual change of character; the presence of speech disturbances and the presence of irregular, periodic, momentary attacks of unconsciousness; the tripillary quality: the irregular, violent attacks of headache; the more marked increase of the deep reflexes on the right side; Babinski and Gordon reflexes on the right side, with their absence on the left, and the general appearance of the patient.

Having decided upon the diagnosis of intracranial growth, a craniotomy was advised, accepted, and the operation performed August 5.

Operation: Craniotomy.

Operator: Dr. Shipley.

Assistant: Dr. Rankin.

Anesthetist: Dr. Broadwater.

Anesthetic: Ether, drop method.

The head having been prepared in the usual manner for an aseptic operation, a curved incision about six inches in length and having its concavity downward was made over temporal fossa on left side, the incision beginning an inch behind external angle of left eye and ending directly over ear. Having cut through and dissected away the fascial and tissues covering the temporal muscle, the fibers of this muscle were exposed and separated, the periosteum of the skull raised and the skull trephined with the Hudson trephine.

Immediately upon the removal of a button of bone the brain was found to be under great tension, the dura bulging perceptibly and the pulsation being more indistinct than normal. The dura was incised, and the brain found to be anemic, slightly edematous in appearance, but pulsating. The second left frontal convolution was punctured, and about 2 ounces of a clear fluid flowed out of the opening. A definite cavity and wall could be made out by introducing a probe into the punctured convolution. Having drained out all the fluid and stopped a rather troublesome oozing from the bone with Horsley's wax, the dura was closed, as were the other layers, muscle, fascia and skin, in order in usual manner.

Patient recovered from the operation with very little reaction, and on the fifth day was allowed to be up in rolling chair. On eighth day stitches were removed, and wound found to have healed by primary intention, approximations being excellent and scar only slightly noticeable.

The operation having been subtemporal, and the fibers of the muscles separated and not cut, there was no depression.

On fifteenth day patient's symptoms had cleared up remarkably, and he feels entirely well.

Examination: Expression good. Gordon reflex present on both sides, Babinski absent on right side.

Patella Reflex: Slightly exaggerated on both sides.

Abdominal Reflexes: Normal.

Co-ordination: Good.

Sensation: Normal.

Cranial Nerves: Normal.

Eyes: Pupils equal and react normally to sight and accommodation.

Motor aphasia has cleared up entirely.

Patient discharged in greatly improved condition and, in his own words, "feeling like a different man."

THE USE OF IODINE AS AN ANTISEPTIC IN SURGICAL AND GYNECOLOGICAL PRACTICE.

By I. S. Stone, M.D., Washington, D. C.

For some years past (January, 1872) we have been using solutions of iodine in our gynecological work and to the exclusion of *nearly all other so-called antiseptics*. Iodine may be relied upon as an antiseptic, disinfectant and deodorizer in every variety of gynecological work. That is to say, it will accomplish anything expected of the other agents of this class without the evil, toxic or undesirable results often observed when antiseptics are used. In the hospital where the greater part of my surgical work is done the odor of iodoform is rarely observed, my colleague and I having voluntarily relinquished its use many years since, at about the same time, but independently of each other. Since then we notice the use of iodoform only when some younger surgeon thinks it necessary. My vaginal hysterectomies, or Wertheim operations, all recover without iodoform as well as they ever did with it. In fact, we can conceive of no necessity for any antiseptic upon gauze in clean abdominal or vaginal work. There are, however, occasions when there is need for thorough cleansing of the uterus,

or possibly an abscess cavity where one wishes to add an antiseptic to the gauze pack or drain. It is in such cases that iodine is quite as satisfactory as any other agent. It is nearly non-toxic and rivals permanganate of potash in its antiseptic qualities. Our constant use of iodine as an antiseptic dates from the time of Senn's adoption of the Claudius method of sterilizing catgut. We think this catgut has been found as germ-free as any other, and hence our adoption of the drug as a bactericide. Iodine has been found capable of better penetration of catgut than any other chemical agent. This fact should favor its use in many instances where there is a demand for an agent which will penetrate into the tissues without destructive action.

The agents which are in constant use in our hospitals, such as hydrogen peroxide, mercuric bichloride and acid carbolic, have a destructive action upon healthy tissues, and wound healing is retarded by their use. Besides their toxic effect, they coagulate albumen and produce a necrosis which must be removed or repaired before such wounds can unite. We therefore use and recommend the use of iodine solutions somewhat as follows:

1. In the vagina and uterine cavity for acute vaginitis and endometritis, or when we believe the mucosa invaded by infection without ocular evidence of inflammatory changes.

2. When the uterus requires curettement for any purpose whatever, as for missed abortion, small fibroid or mucous polypi, or in sapremia, or hemorrhagic endometritis. The gauze packing is saturated with the iodine solution just prior to its use.

3. To any stump left in the abdomen connected with the vagina, uterus or bowel, such as occurs after supravaginal hysterectomy, or appendectomy, excision of diverticulæ, etc., where carbolic acid or similar agents have formerly been used. We now apply iodine (25 per cent.) to the cervix and portio before hysterectomy for tumor. This usually leaves a sterile area through which the uterus is amputated.

4. In any abscess cavity if gauze is needed, as in mammary abscess or in case of hemorrhage after incision requiring gauze packing.

5. On the abdomen or upon any skin surface 5 to 10 minutes before making the incision.

Recently we read in a German medical journal that a surgeon was relying upon this method to the exclusion of all other sterilization of the skin, including the preliminary scrubbing with soap and water. We follow the method outlined below mainly in a class of cases requiring prompt, quick work without prolonged anesthesia. The patient is as carefully prepared in her room and bed as may be done by the ward nurse. This includes plenty of green soap and water and gauze scrubbing. A towel is pinned around the patient to prevent contact with hands, clothes, etc. After arriving in the anesthesia-room the abdomen is painted with 25 per cent. iodine tincture, U. S. P., or equivalent of compound tincture. The painting is usually done before the patient takes the anesthetic, as this leaves nothing to be done but catheterization (if required) before placing the patient upon the operating table. The usual exposure of the abdomen and wetting of the frail patient is to be avoided if one can do so without danger of infection. We believe iodine is capable of sterilizing the skin as well or even better than any other chemical agent, and it enables us to add this important matter of technique, namely, the dry skin instead of a wet one, the desirability of which should be apparent to everyone. As I write this I have received a letter from a friend in Mount Sinai Hospital in New York describing practically the same method as the above. At that hospital the iodine is applied the night before operation, and a second application is made when the patient is placed upon the operating table.

Stoneleigh Court, Washington. D. C.

THE ETIOLOGY OF PERITONITIS.

By F. P. Firer,

Senior Medical Student, University of Maryland.

In considering the etiology of peritonitis, bacteria and their products are of paramount importance, and the sources of infection come, almost without exception, from the outside, either through the walls of the cavity or some one of the intra- or extra-abdominal viscera.

Rare affections, as found secondary to acute rheumatism of joints and nephritis, are probably hematogenous inflammation of the appendix, and bile passages, ulcerations and perforations of the gastrointestinal tract, infection through the Fallopian tubes, thrombosis of any portion of the intestinal tract secondary to mechanical disturbances, rupture of abscesses of any of the organs

in relation to the peritoneum are among the usual sources of peritonitis. The so-called aseptic peritonitis caused by foreign bodies, sponge ligatures, hemorrhage due to trauma, ectopic gestation, outpour of fluid from a ruptured gall-bladder, kidney, cysts of various forms is most liable to become septic by invasion of bacteria.

The subperitoneal tissue is richly supplied with lymphatics and blood vessels, giving rise to the hemotogenous variety of peritonitis, the usual form being secondary to pneumonia, tuberculosis and puerperal invasion. Tuberculosis of the peritoneum is seldom primary, usually resulting from some distant foci, as tuberculosis of the mesenteric or retroperitoneal glands, tubes and ovaries.

Pseudo-tuberculous peritonitis may be produced by bacteria, fungi of different forms, small bits of foreign bodies, animal parasites, etc. Perforative peritonitis is the most important and is a true polyinfection, as many as 10 different species of bacteria having been found. The bacteria most commonly found in peritonitis is the colon bacillus, but the streptococcus and staphylococcus are the usual forms producing this condition, as will be explained later. The pneumococcus, typhoid bacillus, gonococcus are among the most common. Bacillus pyocyaneous is occasionally found. As predisposing factors may be mentioned sudden changes of temperature, suppression of long-standing discharges, malignant tumors, cachexia, long persisting pain and discomfort, secondary mental and nervous phenomena or any condition having a tendency to lower resistance.

The acute and chronic forms of peritonitis are to be differentiated, which may be general or localized. The acute localized peritonitis is seen in cases in which bacteria escapes gradually and in small numbers through the walls of the viscera or in which perforation takes place after the production of some exudate, which serves the purpose of limiting the extension of the infection. This form may often be seen associated with diseases of the tubes or uterus and in the region of the appendix. Acute general peritonitis may be the immediate result of the discharge of a large quantity of infective matter from a perforated bowel or other organ, or occur secondarily to localized peritonitis when the lining wall of exudation is broken down.

The most violent forms of peritonitis may assume a putrid character and the tissues rapidly undergo necrosis.

Chronic peritonitis may be the termination of an acute attack or be chronic from the beginning. It may result from chronic inflammation or a thickening extending from adjunct organs. Thus in cirrhosis of the liver the peritoneum covering the spleen may be involved in consequence of the chronic congestion or inflammation of this organ. Disease of the appendix, uterus, tubes or ovaries may be associated with this form of peritonitis.

Chronic peritonitis may result in replacement of the peritoneum by connective tissue, which mats all the viscera together. Peritonitis may result from undetermined causes, as from syphilis, gonorrhea, rheumatism. There must be some injury to the delicate endothelial cells lining the peritoneum before peritonitis will take place. Among the conditions not previously mentioned may be added the action of chemicals, such as mercuric chloride injections, drying or chilling of the peritoneal surface, excessive handling of the intestines, constant use of stimulating fluids, dysentery, strangulated hernia or anything producing intestinal obstruction, stab wounds and other conditions too many to be enumerated.

The following experiment tends to prove that peritonitis must be produced by some injury to the delicate endothelial cells lining the peritoneum:

The injection of a moderate amount of a cloudy culture of bacteria into the peritoneal cavity produces no peritonitis, neither does the injection of bacteria and their toxins, as both are rapidly absorbed by the healthy peritoneum. Feces are especially dangerous because the foreign particles irritate the peritoneal membrane. They also contain the bacteria, so that the injured area protects them from rapid absorption. When an abscess ruptures into the peritoneal cavity it carries in the discharged pus all of the necessary elements for a spreading infection. The bacteria and toxins which are hidden in the particles of fibrin and necrotic tissue, which acts as an irritant as well as to harbor the bacteria until an inflammation can be started in the, as yet, uninjured peritoneum. Trauma during the course of an operation and the simple presence of bacteria will start an active process, and foreign particles are not necessary to start an inflammation.

The discovery of colon bacillus in the peritoneal fluid a few hours before or after the death

of a patient cannot be assumed as an absolute evidence concerning the infective organism, as one instance is recorded in which one hour after death, due to peritonitis as a terminal infection of cirrhosis of the liver, a small quantity of the exudate was withdrawn by means of a sterile syringe and found to contain a pure culture of pneumococcus. Twenty-six hours after death the cultures obtained from the purulent exudate showed only the presence of vast numbers of colon bacillus. Hence the difficulty encountered in the isolation of a feebly growing pathogenic germ in the presence of a more vigorous saprophyte.

In appendicitis the organ may be surrounded by a pus sac containing nothing but colon bacillus, but its wall upon section, and properly stained, will show throughout its whole thickness streptococci.

EXCESSIVE DIARRHEA IN TYPHOID—ITS CONTROL.

By Nathan Winslow, M.D.

Different authorities and different teachers have various views upon this most perplexing question. Some advise, if the stools number no more than ten or a dozen, to adopt no measures for their control, whilst others suggest the use of chalk mixture, opium, bismuth, etc.; again, still others recommend purgation with calomel and salts in obstinate diarrhea. It has been my custom to keep hands off in the dysenteries of typhoid, but having recently a case with peristent, annoying diarrhea, I spoke to my friend, Dr. William J. Messick, and asked him his experience with the diarrheas of typhoid. Much to my surprise, he replied that in an experience of more than 14 years he had never had a case of typhoid with frequent fecal movements. Upon recognizing that he was dealing with typhoid fever, with a tendency to frequent alvine evacuations, he placed his patient upon resorcin, grains 5, every four hours, and in a very few days the patient was constipated. So, heeding his advice, I resorted to his method of treatment, and within a few days the movements were reduced from 10 to 12 in a day to one or two, with a great deal of relief to the patient both in energy and mental anguish. This is a very simple remedy, with no danger to the patient. Resorcin controls the diarrhea by inhibiting fermentation of the intestinal contents.

Realizing that others are as ignorant as I, this paper was written with the view of aiding them in a like predicament with me.

INFANTILE JAUNDICE.

By Nathan Winslow, M.D.

In the newly-born two varieties of jaundice are encountered: (1) Physiological; (2) Septic.

Physiological.—According to statistics, jaundice makes its appearance in 33 per cent. of all recently-delivered children about the fourth or fifth day of their life. After increasing in severity for a day or two, it slowly disappears. The duration of the average case is three or four days, but at times it lasts a week. It shows no preference for either sex, one being attacked as frequently as the other. It occurs more often in the cases of premature birth. The discoloration is first noticed in the skin of the face and chest, then in the conjunctiva, and finally in the legs and arms. The color of the skin varies from a pale to a dark yellow. Idiopathic jaundice is not associated with any rise of temperature. The intestines are not affected in this form of infantile jaundice. We rarely see any difference in the color of the stools. The urine is very apt to be normal, but at times it may contain bile.

Its pathology is unknown, but some believe it to be hepatogenous in its origin and due to a resorption. In consequence of the great changes taking place in the circulation of the liver as well as in the circulatory fluid itself, there is an engorgement of the portal circulation which presses upon the biliary capillaries and causes a stasis of the bile. Owing to this congestion of the portal circulation, the great destruction of the red corpuscles taking place in the liver and the stasis in the biliary ducts, there is an absorption of bile by the blood vessels. This malady is never fatal, and requires no treatment.

Malignant Jaundice.—Occasionally jaundice is met as a symptom of an infection, for which reason it is spoken of as septic or malignant jaundice. This condition arises in the greatest number of cases from infections taking place through the umbilicus; in fact, 80 per cent. of the infections of the newly-born occur through the above-named source, but wounds or abrasions of the skin or

mucous membrane, such as those caused by the application of forceps, offer also portals of entrance to pathogenic bacteria.

In cases where the umbilicus is the seat of the lesion, the symptoms depend upon the variety and virulence of the organism and the physical condition of the victim. If the invading germ belongs to the staphylococcus group, an omphalitis is present, and if the organism is virulent enough, local abscesses may make their appearance about the seventh or tenth day in the abdominal wall. If the exciting cause is the streptococcus, the infection is much more extensive, and in those cases in which the resisting power of the child is lowered or the germs are extraordinary virulent, the peritoneum is apt to be involved, whence the organisms gain an entrance into the general circulation, giving rise to a septicemia. The etiological factors of septic jaundice are identically the same organisms as those found in adult septicemia. The jaundice associated with septic infection hasn't such an intense hue, but is more persistent than that found in idiopathic jaundice. As septic jaundice is only a symptom of blood poisoning, we will also have all the other signs of septics, such as a weak, rapid, corded pulse; increased, shallow respirations; pinched features; sunken eyes; abdominal distension, tenderness and tympany; reversed peristalsis of the bowels and fecal vomiting; septic temperature. The toxines first stimulate the nervous system, so that the patient is exceedingly irritable and restless. As the poison increases, however, very rapidly, delirium soon gives place to convulsions, stupor or coma. In these cases we obtain histories of the umbilical wound having been handled with no aseptic precautions.

Winkel's Disease.—Sometimes jaundice appears in epidemic form, when it is known as Winkel's disease. The essential features of the disease are hemoglobinuria, with intense icterus of the skin and internal organs. It is a very rare and fatal malady, occurring mainly in institutions. It is undoubtedly due to some infection, and is supposed to be caused by a peculiar form of streptococcus. The symptoms usually begin from the fifth to the eighth day after birth. They are intense and fulminating in character, seldom lasting more than a day or two. The urine is passed frequently, in small quantities, and with strangury. It is of a brown, smoky color, and under the microscope shows the presence of hemoglobin and red blood cells, but it does not contain bile. The jaundice of the skin is intense, and the patient has a brownish hue. All of the cardinal symptoms of sepsis, such as a weak, rapid pulse, shallow, hurried respirations, prostration, delirium, stupor and coma, will be present.

When due to the staphylococcus, the prognosis is good, but in all other instances the case is very likely to end fatally.

The treatment is largely prophylactic. You should treat the umbilicus as aseptically as you would any other wound. In symptomatic jaundice treatment is of little avail, but alcoholic and ammoniacal remedies may be tried. If abscesses are present, open them. Keep the child alive with stimulants, and apply hot-water bags to the extremities. In desperate cases normal salt infusions may be tried.

THE PART THE UNIVERSITY PLAYED IN OPHTHALMOLOGICAL DEVELOPMENT IN AMERICA.

The foundation of the Baltimore Infirmary was laid in 1823, and patients were received the same year. There were four wards, of which one was reserved for eye diseases, instruction in ophthalmic surgery forming a prominent feature in the course (Hubbell, The Development of Ophthalmology in America). Be this as it may, we can find no authentic record as to who gave the course of instruction. He attributes it to George Frick, M.D., a prominent ophthalmologist of the day, and later professor of natural history, University of Maryland.

According to the same authority, George Frick was the first in America to undertake to restrict his professional work almost exclusively to ophthalmology. He was born in Baltimore in 1793. After completing his medical studies and graduating from the University of Pennsylvania in 1815, he was licensed to practice in his native city in 1817. He visited Europe, where he became a favorite pupil of the celebrated Vienna ophthalmologist, Beer. He came to feel deeply the dearth of knowledge of diseases of the eye in America, and set himself to work to so qualify himself under the great master that he might return to his home and give some enlightenment and a scientific uplift to a neglected department of medicine. After a prolonged period of study

and enthused by Beer as an exclusive specialist, he returned to Baltimore in 1818 and undertook in a measure to follow his teacher's example. He at once began his plans for ophthalmologic work. He organized a special eye clinic in connection with the Baltimore Dispensary and established a course of lectures in the University of Maryland. Having tastes for other pursuits, he was led to abandon his profession so well begun. He finally repaired to Dresden, where he died in 1870, at 77 years of age.

Additional notes upon this subject will appear from time to time in the BULLETIN.

PERSONAL NOTICE.

Dr. Allen Keer Bond, class of 1885, of Baltimore, Md., formerly librarian of the Medical and Chirurgical Faculty of Maryland, editor of the Maryland Medical Journal and lecturer on diseases of children and dermatology in the Baltimore Medical College, was born March 16, 1859, at Kalmia, Harford County, Maryland, on lands which were deeded to his ancestors by Lord Baltimore in the early time of the colony. He is of American and Scotch ancestry, and comes of a family of physicians, of some of whom a brief mention is opportune.

His great-grandfather, Dr. Solomon Birckhead, was an eminent and highly-esteemed physician, the period of whose active life included parts of two centuries. He was born at Cambridge, Md., July 21, 1761; graduated in medicine from the University of Pennsylvania in 1783; was treasurer of the Medical and Chirurgical Faculty of Maryland from 1809 to 1811; consulting physician to Baltimore Hospital in 1812, and died in Baltimore November 30, 1836.

Dr. Thomas Emerson Bond, grandfather of Dr. Allen Kerr Bond, was born in the city of Baltimore in February, 1782, and was one of the most distinguished physicians of his time. He graduated in medicine at the University of Pennsylvania in 1819, and also received the degree of D.D. He practiced in Baltimore many years, and was president of the Medical and Chirurgical Society of Baltimore, 1832-33; member of the City Council in 1837; president of the City Board of Health in 1839; president of the board of Trustees of Baltimore College of Dental Surgery, 1839. He also was a local preacher of the Methodist Episcopal Church, and his zeal and ability procured him the title of "Defender of the Church." He was editor of the *Itinerant*, 1830-31, and of the *Christian Advocate and Journal* of New York for 12 years, 1840-52. Dr. Bond died in New York city March 14, 1856.

Dr. Thomas Emerson Bond, Jr., son of the above mentioned and father of Dr. Allen Kerr Bond, was born in Harford County, Maryland, in November, 1813, and received the M.A. degree from Baltimore College in 1830 and the degree of M.D. from the University of Maryland in 1824. He practiced in Baltimore about 15 years, and in 1853 returned to his native county, and afterwards devoted his attention to literary and church work, for he, too, was a local preacher of the Methodist Episcopal Church. In 1839 he helped to found the Baltimore College of Dental Surgery, and was its professor of special pathology and therapeutics from 1839 to 1872, and dean of the college from 1842 to 1849. He was a member of the City Council in 1847; professor of materia medica and hygiene in Washington University, Baltimore, from 1842 to 1851, and in 1867 took a prominent part in the work of reorganizing the University.

As an author and editor Dr. Bond enjoyed a wide reputation. His first published work was "Treatise on First Dentition" (from the French of M. Baumes), New York, 1841, which was followed by his "Treatise on Dental Medicine," 8 v., Philadelphia, 1851-52. He was also author of "The Life of John Knox"; joint editor of *The Guardian of Health*, 1841; editor of *The Baltimore Christian Advocate* and the *Episcopal Methodist*. Dr. Bond died August 19, 1872.

Dr. Allen Kerr Bond acquired his earlier literary education in Belair Academy, Curtis Academy, at Fallston, Md., and George C. Carey's private school, in Baltimore, and his higher education at the Johns Hopkins University, where he graduated with the degree of B.A., in 1880. He was educated for the profession of Medicine at the University of Maryland School of Medicine, graduating from that institution as Tiffany prizeman, with the degree of M.D., in 1882. In 1882-83 he was a resident physician to Bayview Hospital. In 1885-86 he took special courses in the Imperial Hospital at Vienna, Austria. He has, since graduating, engaged in the practice of his profession as his forbears in Baltimore, and in connection therewith has given of his time to hospital and editorial work, and also to professional attendance at various eleemosynary insti-

tutions. In 1884 he was librarian of the Medical and Chirurgical Faculty of Maryland, and for five years lecturer on diseases of children and dermatology in the Baltimore Medical College. For some years, also, he was editor of the *Maryland Medical Journal.*

He became a member of the Medical and Chirurgical Faculty in 1888. He was a member of the Baltimore Academy of Medicine, the Maryland Public Health Association, the Clinical Society of Baltimore and the Baltimore Medical and Surgical Association. Dr. Bond has published many clinical and philosophical studies in medicine, and also a volume entitled "How Can I Cure My Indigestion" (Contempary Publishing Co., New York). He married August 2, 1908, Louise Birckhead Gambrall, daughter of the late Rev. T. C. Gambrall and Susan B. Gambrall. He resides at 949 Park avenue, Baltimore. Dr. Bond is a friend and admirer of the University, and a well-wisher for its success. He takes pride in its advancement and evidence of renewed progressiveness.

URINARY CALCULUS, WITH OPERATION.

By R. R. Norris, M.D., Class of 1907, Crisfield, Md.,

Former Chief Resident Physician Bayview Hospital.

The case I want to bring to your attention tonight is one that came under my observation at Bayview when I was chief resident physician of the Almshouse Department. When I first came on the staff the case was pointed out to me as a case of chronic cystitis in an old woman who was irritable and hard to manage. She was then being irrigated with boracic acid, but did not show much improvement. To be brief, 10 days after I saw her she was removed from Bayview and taken to her son's home in Baltimroe; she remained there a while, and was then taken to the Hopkins Hospital, then to the Hebrew Hospital, and after a period of about three months she came back to Bayview with no improvement. I will now give you the history of the case.

Mrs. A. G.; age, 69; nationality, Hebrew; first admittance to Bayview, December 1, 1905; discharged, June 20, 1906; second admission, September 11, 1906.

Married; has had three children; no miscarriages; menstrual history was always regular; had metapause at 45.

Family history: Negative, except father died of Bright's disease.

Past history: Had all diseases of childhood, but was always a strong child.

Present history: Has not been well for three years, having suffered with a great deal of pain in the region of the bladder, and complains of dribbling of urine all the time; has not much appetite; feels too weak to walk, and wants to stay in bed all the time. She also suffers at times with attacks of asthma.

Arteries hard. Heart—a distinct mitral murmur is present, and can be heard very plainly.

Lungs—on ausculation feeble visicular murmurs, associated with wheezing sonorous rales.

Percussion—hyporesonance over both lungs.

Urine—albumin marked; spg. low; no sugar.

Micropical—great abundance of pus cell; epithelium; also hyline and granular casts.

On the last admission to Bayview I made a careful examination, but could find no evidence of stone in the bladder, except pain and objective symptoms given above.

I ordered her irrigated, intending in the meanwhile to watch developments. After a day or two the nurse reported that she could not get the catheter into the urethra. I went down and tried it myself, and found the glass catheter struck something metallic and hard, which turned out to be a large stone situated in the lower part of the bladder, filling up the whole inclosure of the urethra.

Owing to the age and extremely bad physical condition of the patient, I hesitated operating, but, finding she could not void now without having the stone pushed back with a catheter to let the urine escape, and that this gave her much pain, I finally decided to operate, and after a lot of persuasion secured her consent to be operated upon.

The operation was set for two days from this date, but in the meanwhile she was taken with a bad attack of asthma, which came near causing her death.

However, this cleared up fairly well, and in a week I had her prepared for operation, having first previously ordered her to have plenty of water, a tonic T. I. D. and urotropin, grains 5, morning and evening.

On September 28, 1906, at 10 A. M., she was brought in the operating-room prepared for operation. I desired to enter the bladder through the vagina, as I had to be quick and could give but very little ether, owing to the bad physical condition.

I washed the vagina out well, and, having an assistant hold the vagina open with retractors, I passed a grooved steel male catheter through the urethra, the blade going downward. Using the catheter as a guide, I made a small incision about an inch below the urethra, cutting through the mucous membrane of the vagina into the bladder. I next passed a pair of bullet forceps in, grabbed the stone and removed it intact, as you see by the specimen.

I then washed the bladder thoroughly with a hot boracic solution, and after getting out as much pus as possible, I closed the wound with three fine black silk sutures, rather close together. Then taking two small rubber catheters which had been previously tied together and boiled, I passed them down the urethra into the bladder.

Patient was removed to bed. I attached one of the catheters just mentioned to an irrigating jar, letting a hot boracic solution pass into the bladder through one catheter and out into a pail through the other. I kept this irrigation up about 36 hours, then examined the wound, and found it almost healed. At the end of five days I took out the sutures, and the wound was about closed. I got the patient out of bed into an easy chair. She voided involuntarily for about a week, but at the end of this time she suffered no pain or inconvenience, and in two weeks the wound closed entirely, and she was able to retain and pass her urine at her will. Owing to her age and general debility, she could not get around very well, but when I left Bayview, 11 months after, she was in good shape as far as the bladder trouble was concerned.

April 5, 1909.

ACADEMIC DAY AT THE UNIVERSITY OF MARYLAND.

The University of Maryland's academic day exercises, commemorating the one hundred and twentieth anniversary of St. John's College, which was affiliated with the university two years ago, were held at Westminster Presbyterian Church, Fayette and Greene streets, Thursday morning, November 11.

A memorial address in honor of John Prestiss Poe, late secretary of the regents, dean of the faculty of law, and for 40 years a professor of law in the university, by Judge Henry D. Harlan, marked the exercises. The degree of doctor of laws was conferred upon State Comptroller Joshua W. Hering and Dr. Charles Horace Mayo of Minnesota.

At 10.30 o'clock the faculty and students of the university assembled and marched to the church. The line was formed of students from the department of arts and sciences of St. John's College, the departments of medicine and pharmacy, the chancellor, the provost and regents of the university, the faculties and adjutant faculties, orators and guests and the alumni.

The exercises were opened with an invocation by Rev. Thomas Grier Koontz, pastor of the church.

In the absence of the provost, Mr. Bernard Carter, the greeting was made by Judge Henry Stockbridge. He declared that the occasion was one which brought the several departments of the university into closer touch and served as a medium for the interchange of greetings between the university and other institutions of the country.

"It enables the university," he said, "to express its good-will and aims to its students and their friends and all others interested in elevating the standard of professional and technical training."

Announcements of chairs to be filled to take Mr. Poe's place were made by Judge Stockbridge. Judge Harlan was elected to succeed Mr. Poe as dean of the law department, and Mr. William L. Marbury of the class of 1882 to lecture on the subject of torts during the second half of the year. Judge James B. Gorter will become lecturer on evidence, and Mr. Joseph C. France on pleading and practice.

This distributes among three the courses previously directed by Mr. Poe. In accepting the position as lecturer on pleading and practice, Mr. France retires as lecturer on elementary law and jurisprudence. No selection has yet been made to fill the vacancy.

Messrs. Hobart Smoek and B. Merrill Hopkinson sang "Guide, O Thou Great Jehovah." The balance of the musical program was under the direction of Dr. Hopkinson.

Judge Harlan eulogized Mr. Poe, saying, in part:

"It has been deemed appropriate that this first meeting since the death of the late dean of the law school, when are assembled the faculties and the students, many alumni and friends of this university, should not pass without some account of the life and tribute to the memory of one whose work has been so conspicious; whose claims to the love and honor of all connected with it are so strong, and whose presence is missed today.

"The duty of paying this tribute has been intrusted by the regents to me. I regret, however, that I am not better qualified to discharge it according to its deserts. In view, however, of the fact that for 30 or 40 years, through which his labors were extended, I have been a daily witness of their performance, and for more than 25 years —no inconsiderable period—have served with him in the school of law, I recognize that the mandate of the regents is not wholly unjustified, and it will afford me at least the opportunity to express my gratitude to and my abiding respect and affection for one who was my legal preceptor, and for all these years my warm and devoted friend."

Judge Harlan gave a history of the Poe family, and told of Mr. Poe's career as one of the State's ablest and most learned lawyers. He also told of the great interest Mr. Poe had always taken in the work of the university and his impression on the young men with whom he came in contact. He concluded by relating the bravery of such a distinguished man, and said it only remained for him to read the minute adopted by the regents. It told of their personal sorrow and the loss felt by the university.

The principal address of the day was made by Dr. Archibald L. Bouton, professor in the department of English literature at the University of New York. He spoke on "Is Culture Worth While?" and said in part:

"Every autumn many of the colleges of New England set apart a day called Mountain Day, when the students lay aside their work and ramble over the neighboring mountains, to appreciate the glorious outlines of the October landscape and to imbibe something of the serenity and strength of the hills. Every October the university with which I am concerned, with a somewhat analogous motive, sets apart a day called Founders' Day, in which the thought of our students is directed backward over the lapse of more than 75 years, to dwell upon the personality and ideals of those who established the university.

"To us in like manner Founders' Day brings an opportunity to draw strength to ourselves from contemplating the foresight, the self-sacrifice, the high idealism of the men whose labors have made the university and our present opportunities possible.

"I do not know how long the University of Maryland has observed the custom of Academic Day. I know that as a university you look backward to your founding for more than a century of usefulness. I know little of the special customs and ceremonies which have been associated with Academic Day in the past. I cannot be far wrong in seeing in it something of the character of an intellectual Mountain Day, when we may look for a broader outlook and meditate on some of the special problems of university life."

Professor Bouton told of the university life and the many advantages of the culture to be had there. He pointed out a number of reasons why students should make something of themselves and why they should aspire to know as much as their professors.

In conclusion, he said:

"The hour of our responsibility has come. In my attempt to present the conceptions of a real culture, it seems to me that in them lie the broad fields of a new land of promise, toward which America is now ready to move and to which the eyes of her people are already lifted."

PORTRAIT OF MR. POE PRESENTED.

A portrait of Mr. Poe by Dietrich was presented the university by the students of the department of law. The presentation speech was made by Charles O. Laney, a student. It was accepted by Judge Stockbridge, and will be hung in the university.

After the presentation honorary degrees were conferred on Drs. Hering and Mayo. In bestowing the honors a short sketch of their lives was read by the provost. Afterwards the students gave class yells and called for speeches. At one time the applause lasted five minutes.

After the exercises, which lasted nearly two hours, the faculty and guests had luncheon at Germania Mænnerchor Hall. The St. John's College cadets returned to Annapolis on special cars of the Washington, Baltimore and Annapolis Electric Railway.

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FOUNDERS' DAY.

The exercises of Founders' Day at the University of Maryland, held on November 11th, were of an imposing and impressive character. The faculties and students of all the departments assembled on the grounds of the University and marched in a body to old Westminster Church, S. E. corner Fayette and Greene streets, where the exercises were held.

In the absence of the Hon. Bernard Carter, provost, on account of sickness, Judge Henry Stockbridge officiated as provost, and conducted the services in a most happy and successful manner.

The first address, delivered by Judge Henry Harlan, was a memorial on the life and services of the late Hon. John P. Poe, for so many years Dean of the Law Department and Secretary of the Board of Regents. Judge Harlan paid a most beautiful and graceful tribute to Mr. Poe in an address marked for its scholarship and faithful presentation of the great services Mr. Poe had rendered the State and University of Maryland.

The next address was delivered by Dr. A. L. Bouton of the University of New York on the subject, "Is Culture Worth While?"

Dr. Bouton handled his subject in a most scholarly and exhaustive manner, and succeeded in convincing the audience that culture is worth while.

The honorary degree of LL.D. was next conferred by Judge Stockbridge on behalf of the Regents of the University of Maryland on the Hon. Joshua L. Hering of the class of 1855, now Comptroller of the State of Maryland and President of the Board of Trustees of Western Maryland College, and upon Dr. Charles H. Mayo of Rochester, Minn., the distinguished surgeon, who, on the 9th and 10th of November, had delivered lectures on the "Surgery of the Thyroid" before the students of the University and invited guests of the Faculty of Physics in Chemical Hall.

The exercises were interspersed with vocal music under the direction of Dr. B. Merrill Hopkinson, an alumnus of the University. It is estimated that there were over 800 students of the various departments present, in addition to their friends and members of the different teaching bodies.

This the second celebration of Founders' Day at the University of Maryland was a most successful occasion, and marks the permanent observance of this academic function in the future work of the University.

In other words, Founders' Day has come to stay, and from year to year as time rolls on the exercises of this day may be regarded as milestones to mark the progress of the University in the great work she is destined to do in the world of education for the people of Maryland and for her growing student bodies filled with recruits from all parts of our land and foreign lands.

This day, so auspiciously inaugurated last year, has done more to strengthen the bonds of union between the departments of the University and to build up a university life and spirit than all the agencies hitherto employed. Each year these bonds will strengthen, and at no far distant day the friends of the University will find an organization and administration which will conduct the affairs of the University along broader and more progressive lines. As sure as the world runs its daily course, just so sure will these improvements and reforms come in the work of the old University. Her friends are growing, the public interest in her affairs is increasing and her present governing body is moving with caution, but with resolute purpose, in the right direction. Her continued growth, usefulness and prosperity are assured.

THE CARROLL FUND.

Merit has her reward. The committee in charge of the Carroll Fund request no further contributions be made, as sufficient money for the purpose in hand. Alumni of the University of Maryland should feel a pang of pride that the medical pro-

fession of the United States at large has adjudged the labors of a brother alumnus of so marked distinction as to merit their contributions to help raise a mortgage on the home of his widow. The Journal of the American Medical Association editorially voices these sentiments on the completion of the fund:

"It will gratify all to learn of the completion of the fund for a home for the wife of Major Carroll of yellow-fever fame. Major Ireland, of the medical corps of the Army, who so kindly assumer charge of the receiving of remittances, announces that the contributions now in his hands are sufficient to pay off the entire indebtedness on the property and leave a small balance. Further contributions for this fund are, therefore, unnecessary. The committee is to be congratulated on the able and rapid manner in which it has raised this amount, and the profession at large, and others, are to be thanked for the manner in which they generously and promptly responded to the appeal for contributions. The success of this undertaking is an evidence of the honor and esteem in which Dr. Carroll's memory is held for his self-sacrifice which led indirectly to his fatal affliction. In suffering himself to be bitten by yellow-fever mosquitoes as one of the necessary steps in solving the problem of that disease, Dr. Carroll merely followed what seemed to him to be in the line of duty. But history inscribes his name among the heroes and martyrs, and enrolls among his debtors not only his profession and science, but also commerce, his nation and the whole world."

ABSTRACTS.

Benign Tumors of the Turbinated Bodies Clinically and Pathologically Considered.

According to Richard H. Johnston, class of 1894, Journal of AM. A., July 24, 1909. Excluding nasay polypi, benign tumors of the turbinated bodies are very rare. Less than twenty true papillomata of the nasal cavities have been recorded in rhinologic literature. In a special practice of eight years he has only seen clinically three benign tumors of the turbinated bodies, and has examined pathologically three other benign growths referred to him by other rhinologists. Of the six patients four were female and two males, their ages ranged from 12 to 60 years. In sum arizing he calls especial attention to the possibility of the transformation of benign into malignant growths.

Mr. and Mrs. H. M. Turner, of Shepherdstown, West Virginia, have announced the engagement of their daughter, Miss Loraine Turner, to Doctor Nathaniel Burwell, class of 1907. Doctor Burwell is a native of Clarke county, Virginia, and is a practicing physician of Shepherdstown. The wedding will take place in October.

"The Recorder," the official organ of the "Supreme Ruling of the Fraternal Mystic Circle," of August made the following eulogistic remarks about Doctor Arthur E. Ewens, class of 1904, of Atlantic City, New Jersey:

THE LATE HON. JOHN P. POE'S CONNECTION WITH THE UNIVERSITY OF MARYLAND.

Seldom in the life of a teacher, and especially in the case of a professional man in the pursuit of law or medicine, does it happen that a preceptor retains the same chair in an institution for a term approaching twoscore years, but this honor belongs to Mr. Poe, who this fall began his fortieth year as professor of pleading and practice in the Maryland University Law School.

In October of 1870 Mr. Poe began his lectures on "Pleading and Practice," and in 1872 the additional course of "The Law of Evidence" was added to his work in the law school. A third subject, "Legal Ethics," was assigned to him last year on account of the retirement of Prof. John J. Donaldson from the chair of jurisprudence and ethics.

In opening his course of lectures at the university several weeks ago Mr. Poe called attention to his long term of service and said:

"Thirty-nine years is a long time, and in that span I have seen many students come and go. I also call to mind some of the most distinguished professors of this school, and some of the most conspicuous and eminent of our judges with whom I have been closely acquainted. I merely call this to your mind as an encouragement and inspiration to follow in the steps of your distinguished alumni, and in the years to come to add fresh glory and renown upon your alma mater."

"In the autumn of 1869 I was notified that the vacancies then existing in the board of regents of the School of Law of the University of Maryland

had been filled by the election of Hon. George William Brown (afterward Chief Judge Brown), Messrs. Bernard Carter, Henry Clay Dallam and myself.

"We accepted the positions which we were then called to fill in the law department of the university. The exercises, which had been suspended for a number of years, were resumed. The department was reorganized by the election of the late Judge John A. Inglis as the professor of law and as such a member of the board of regents, and the late Judge Robert N. Martin as a professor.

"Lectures in the Law School were begun in February, 1870, and were regularly delivered to a very small class by Judges Inglis and Martin until the summer recess of that year. In the summer of 1870 Judge Robert N. Martin died suddenly, and the vacancy was filled by the election of Judge Alexander H. Handy, formerly Chief Justice of the Court of Errors and Appeals of Mississippi.

"I was called to the chair of pleading and practice in courts of law, and began my lectures in October, 1870. My class during that university year numbered sometimes three and occasionally as many as seven. My lectures were all delivered at night.

"In 1872 the additional subject, the 'Law of Evidence,' was assigned to me. I have been continually engaged in the work of instruction in this law school since 1870.

"Prof. Samuel C. Chew of the faculty of physic and I are the only survivors of the board of regents at the time of my election.

"The late Severn Teackle Wallis was unanimously elected in 1870 as provost of the university to take the place of Hon. John P. Kennedy, who had filled that office from 1850 until his death. Mr. Wallis held the office of provost until his death in April, 1894, and in June, 1894, Mr. Bernard Carter was elected provost, which office he still holds."

ITEMS

Dr. Ejnar Hansen, 41 E. 41st street, New York, writes to the BULLETIN:

"Inclosed a check for subscription. Could I from you get a list of the physicians—graduates from our old school—now practicing in New York city? I should like to find them, and, if possible, start a little University of Maryland Society here in New York city. The BULLETIN is a welcome guest in my home every month, and I read it from beginning to end, trying in that way to keep in touch with the school hospital and old friends. Success to you."

Dr. Platt W. Covington, class of 1908, after one year of service as pathological to the Maryland Hospital for the Insane has returned to his home in Rockingham, N. C., for private practice.

Dr. Summerfield B. Bond, chief medical examiner of the Baltimore & Ohio Railroad, attended a joint meeting of the chief examiners of a number of the more important railroads of the United States. The meeting was for the purpose of the interchange of experience and in a general way to promote the work of the medical and surgical corps under their direction. The meeting was held in the B. & O. Building, Baltimore.

The senior class of the Medical Department of the University of Maryland has elected the following officers for the ensuing year: President, Frank P. Fiery, Maryland; Vice-President, R. R. Diller, Maryland; Secretary, C. N. Devilbiss, Maryland; Treasurer, E. H. Kloman, Virginia; Historian, A. L. Little, North Carolina; Sergeant-at-Arms, M. S. Hanna, Egypt; Class Artist, G. S. Condit, West Virginia. Executive Committee, M. G. Hoffman, West Virginia (chairman); W. A. Gracie, Maryland; M. E. B. Owens, South Carolina; J. E. Talbott, Maryland; J. H. Von Dreele, Maryland; J. E. O'Neill, Maryland; T. Brooks, Cuba.

The annual reception to the old and new students by the Young Men's Christian Association of the University of Maryland was given Monday evening, October 11, 1909, at 8 o'clock, in the association room, Davidge Hall. Dr. S. C. Chew and Judge Henry D. Harlan delivered addresses, and a pleasant musical program was rendered. Refreshments were served after the exercises.

Doctors
J. Wm. Funk,
F. Caruthers,
Wm. S. Smith,
Harry Gross,
A. D. McConachie,
A. T. Chambers
are visiting surgeons to Franklin Square Hospital.

Drs. C. Urban Smith and Wm. H. Pearce are visiting physicians to the Franklin Square Hospital.

Dr. T. J. O'Donnell is chief of clinic to the professor of operative surgery, Franklin Square Hospital.

Dr. and Mrs. William Hewson Baltzell of Wellesley, Mass., are stoping at the Belvedere, having come to Baltimore for the wedding of Miss Agnes L. Selden.

Dr. John S. Fulton has returned to Baltimore after spending the latter part of the summer in Europe.

Dr. Thomas C. Worthington has returned from abroad, where he spent his summer vacation.

Dr. J. N. Reik has returned home from Europe, where he attended the International Medical Congress at Budapest.

Dr. Frank Martin is home after a delightful summer spent on the Continent.

Dr. Ridgely B. Warfield summered in Europe.

Dr. B. Bernard Browne, professor of gynecology in the Woman's Medical College, Baltimore, has resigned.

Dr. J. Howard Iglehart has been reappointed a medical inspector for the public schools of Baltimore.

The junior class of the University of Maryland Medical Department has elected for the ensuing year the following officers: President, Willis Lynn, New York; Vice-President, William L. Byerly, Maryland; Secretary, B. S. Boyer, Maryland; Treasurer, Louis H. Douglas, Maryland; Historian, Henry D. Causey, Delaware; Sergeant-at-Arms, Kenneth B. Jones, Maryland.

Dr. and Mrs. J. Whitridge Williams have returned from an extended stay abroad, which they spent most of the time in Heidelburg, Germany. They have reopened their residence, 1128 Cathedral street, for the winter.

Dr. and Mrs. Cary B. Gamble, Jr., of 26 W. Biddle street, have returned from North Hatley, Canada, where they spent the summer.

Dr. William Dodd Scott, Jr., class of 1904, of Baltimore, has been confined to the University Hospital for the past month with typhoid fever. We are glad to report that he is canvalescing and well on the way to recovery. When he gets out he expects to return to his former home in Fredericksburg, Va., where he will spend some time recuperating.

At the section on Neurology and Psychiatry of the Baltimore City Medical Society, Friday, October 15, 1909, papers were read by Dr. W. F. Schwartz on "Psychasthenia," and Drs. I. S. Spear and R. P. Bay on "Astereognosis, with Report of Cases."

Dr. Caleb Noble Athey, class of 1894, and Mrs. Athey, have returned from their honeymoon, which they spent in Europe. Mrs. Athey, née Miss Helen Skipwith Wilmer, is a graduate of the Johns Hopkins Hospital Training School for Nurses. She met Dr. Athey while engaged in social service work.

At the regular meeting of the University of Maryland Medical Association, held in the amphitheatre of the University Hospital Tuesday, October 19, 1909, at 8.30 P. M., the program was as follows:

Peritonitis, Etiology—F. P. Fiery, class of 1910.

Symptoms and Diagnosis—Dr. Messick.

Treatment—Dr. Shipley.

This society was created especially for the purpose of bringing the faculty and student body closer together, both socially and instructively. At last we seem to have hit the keynote of success by obtaining the interest and co-operation of the students by appointing a member from the senior class to present a paper to the body. The selection of the subject for discussion is left to a committee of students, who, with the president of the society, arrange the program.

These meetings are always very instructive, and this especial one was extremely so. The symptoms, etiology and treatment of peritonitis was

thoroughly discussed. There was also an election of officers for the ensuing year, which resulted as follows: President, Dr. John T. O'Mara; Vice-President, Dr. C. W. McElfresh; Secretary, Dr. Salvatore Demarco.

Dr. Nathaniel R. Keirle, class of 1858, superintendent of the Pasteur Department of the Mercy Hospital, who celebrated his 76th birthday Sunday, October 10, 1909, was given a banquet at the Maryland Club Monday night, October 11, in recognition of his distinguished service to science in combating the ravages of rabies. The gathering included leaders in the medical profession.

All of Dr. Keirle's writings on rabies had been collected by his associates and friends in an attractive volume under the title "Studies in Rabies." The introduction was written by Dr. William H. Welch, the noted pathologist and scientist, while Dr. Harry Friedenwald contributed a sketch of Dr. Keirle's life.

Dr. Friedenwald presented the book to Dr. Keirle, and copies were later distributed to all the guests. Copies will be sent to medical libraries in this and foreign countries.

In presenting the book Dr. Friedenwald said: "We have published this collection of your writings on rabies both for their intrinsic worth and as a mark of esteem and admiration of a large number of your friends and collegiates, who are present at this dinner given in your honor.

"Your work as a teacher, the scientific stamp of your studies and publications, but most of all your painstaking and successful labors in the preventive treatment of rabies, have merited the highest approbation. Your care and accuracy, your untiring persistence and your unwillingness to accept conclusions until thoroughly proved have characterized you as a true scholar and an example of devotion to science.

"You have not been spared disappointment, and you have suffered the greatest of sorrows, but you have borne them with heroic fortitude. Your friends have shared them with you, as they likewise take pleasure in your labors and success. For them all we express the wish for your continued health, vigor and strength steadfastly to pursue your beneficent work.

"In presenting you with your writings in this volume we feel that in honoring you we are showing honor to a true physician, a real scholar, a rare, cultured and noble man."

Others who spoke were Judge James P. Gorter, Dr. William H. Welch, Dr. William S. Thayer, Dr. A. C. Harrison, Dr. G. Milton Linthicum, Dr. John D. Blake, Dr. W. R. Stokes.

Dr. and Mrs. Eugene F. Raphel are visiting in the West. On their return they will stop off at Buffalo, Niagara Falls and New York, and will spend a week with Mrs. Raphel's parents, Mr. and Mrs. A. V. Cherbonnier, 2230 N. Calvert street, before returning to their home, Woodlawn, Wheeling, W. Va.

We are glad to announce to the many friends of Dr. John T. King, who was compelled to go to Atlantic City for his health, that he has returned greatly improved, and is again about his professional services.

Dr. Albert Chase Trull, class of 1909, is to be congratulated as the high man at the last examination of the Maryland Board of Medical Examiners. Dr. Trull made a total of more than 91 per cent. It is such as he who shed credit upon the old University and encourage us in our work. We are not, as some say, retrograding, but are surely and steadily coming to the forefront, as witnessed by our men leading not only the Maryland Board, but also the North Carolina; namely, Doctor Branch Craige.

We have our faults; so have the others. One on the inside always hears more about his own ailment than he does about his next door neighbor's. Instead of proclaiming them to the world, try to correct the imperfections. The best way to do this is, in common vernacular, to loosen up. Money talks. With an endowment we can and will imitate and go one better some of the richer institutions which are always held up to us as living examples of progressiveness. Could they or would they do any better than us with our means? We do not hesitate to reply no.

We are sorry to announce that Miss Frances B. Daniel, a graduate of the Nurses' Training School of the University Hospital, class of 1901, has been

compelled to go to Saranac to take treatment. We are informed that Miss Daniel is in very poor health.

Dr. Lawrence Kolb, Assistant Surgeon United States Public Health and Marine-Hospital Service, has been relieved from duty at Baltimore and directed to proceed to the Reedy Island Quarantine Station and report to the medical officer in command for duty and assignment to quarters.

Prof. and Mrs. John C. Hemmeter were guests of Prof. Franz Pfaff of the Faculty of Medicine of Harvard University. Prof. Hemmeter represented the University of Maryland at the ceremonies of inauguration of Dr. A. Lawrence Lowell as president of Harvard University.

At a meeting of the class of 1812 of the University of Maryland (medical), E. P. Kolb was elected president; E. S. Johnson, secretary, and J. E. Hubbard, treasurer for the ensuing year. R. V. Parlett was elected vice-president and W. T. Chipman sergeant-at-arms.

After the meeting there was a discussion as to the discontinuance of hazing, and the freshmen were informed that if they obey the rules made by the sophomores no more hazing will take place.

The question of hazing in our schools, medical, dental and pharmacal, has become a serious issue, and it behooves the authorities of our institution to put their foot down on the practice and stamp it out every time it raises its obnoxious head. The men who enter our professional schools are supposed to have attended college and there to have indulged in such barbarious practices. When they enter the medical school they are presumed to be men who are done with babyism and to be ready for work. The sophomore class should be allowed to impose no restrictions upon the freshmen of any sort, and the first year men should be encouraged in every way to infringe upon the so-called privileges of the upper class men.

Dr. H. Y. Righton of Savannah, Ga., has been visiting friends in Baltimore.

Dr. and Mrs. David M. R. Culbreth have returned from Spring Lake, N. J., and a trip through New York State, and have opened their residence, 1307 N. Calvert street, for the winter.

Dr. and Mrs. Summerfield B. Bond and their daughter, Miss Lydia Bond, have returned from North Hatley, Canada, where they spent the summer, and are at their home, 1023 Cathedral street.

Dr. George M. Settle of 2435 Maryland avenue, a graduate of the University of Pennsylvania and an assistant in the Nervous Department of the University of Maryland, was operated on recently at the University Hospital and is making a favorable recovery.

Governor Crothers has appointed Dr. W. P. E. Wise, class of 1889, of Baltimore county, a member of the Board of Visitors of the Asylum and Training School for the Feeble-Minded, vice Thomas Hill, deceased.

Dr. L. M. Allen, Associate Professor of Obstetrics, read a paper on Caesarean section before the Section on Gynecology and Obstetrics.

Dr. James A. Nydegger, surgeon, United States Public Health and Marine Hospital Service, granted one month's leave of absence from September 10, 1909.

Dr. Alberto L. Bartlett, class of 1904, has been made local head of the National Sanitary Board, Placentas, Cuba.

Dr. H. W. Wickes, passed assistant surgeon, United States Public Health and Marine Hospital Service, granted fifteen days' leave of absence from September 1, 1909.

Dr. James W. Hart, first lieutenant, Medical Reserve Corps, has been relieved from additional duty at Fort Washington, Md., and duty at Fort Hunt, Va., and ordered to proceed to Cayay, Porto Rico, for duty.

Dr. James S. Fox, first lieutenant, Medical Reserve Corps, ordered to Fort Andrews, Mass., for temporary duty, and on its completion to return to his proper station.

Dr. Eugene F. Cordell, librarian of the medical department of the University of Maryland, informs us that there are upon the shelves more than five hundred copies of general literature.

This fact is not generally known, either by the profession or the student body, therefore we take this method of bringing it to your attention, both with the idea that our alumni in disposing of books of this character will not forget us and that students may avail themselves of the collection. Dr. Cordell's idea in founding this branch of the library is not merely the creation of a nucleus from which in days to come a large general library may grow. It is his idea that our university should have books upon general topics for the relaxation and edification of our students. The editors of THE BULLETIN agree with him and solicit through its columns works upon general literature. Donors may rest assured that any contributions will receive proper care and attention, as their donations will be housed in Davidge Hall under the supervision of Dr. Cardell. The editors also take this opportunity to thank those who have in the past contributed so generously to our library, and whose contributions have augmented the collection so that there are now about 10,000 volumes upon the shelves.

DEATHS

Dr. Hammond Hampton Garner, class of 1902, of Lake Toxaway, N. C., surgeon of the steamer Dextero, died in the City Hospital, Santos, Brazil, South America, in July, aged 31.

Dr. Felix Jenkins, class of 1849, one of the best-known physicians of Baltimore, died Saturday, October 9, 1909, within two days of the 85th anniversary of his birth at the residence of his son-in-law, Thomas W. Offutt, at Towson, Md., death being due to the infirmities of age.

Dr. Jenkins was born in Baltimore October 11, 1824, at what was then 10 South street. He was a son of the late Felix Jenkins, and was educated at Mount St. Mary's College. After taking the full course in medicine he engaged in practice in this city. For 50 years he enjoyed a lucrative practice, and attained a high position in professional circles. He retired from active practice about six years ago, though still retaining his residence, 400 Cathedral street, where he had lived for 25 years. Two years ago he was injured by a fall in front of the Cathedral, since which he has been an invalid. The past few months he had been visiting his daughter, Mrs. Offutt, at her country home near Towson. His wife, who was Miss Nancy Jenkins Conewauga of Pennsylvania, died three years ago. He was a member of the Cathedral parish, and had been a trustee of the church for many years. He is survived by Dr. Felix Jenkins, Jr., class of 1887, Benjamin W. Jenkins of Wilkes-Barre, Mrs. Hughes and Mrs. Offutt.

The funeral took place Saturday, October 12, at 10 o'clock A. M. from the Cathedral, where a solemn high mass was celebrated. Cardinal Gibbons was in the sanctuary during the mass and pronounced the benediction. The mass was celebrated by Reverend Louis O'Donovan, assisted by Reverend P. C. Gavan as deacon, and Reverend William A. Fletcher as subdeacon. The honorary pallbearers were Messrs. Michael Jenkins, E. Austin Jenkins, Robert H. Jenkins, James Hunter, Charles J. Bonaparte, Richard Cromwell, Charles B. Tiernan, Dr. Edward F. Milholland, Dr. Robert Johnston and Dr. Charles O'Donovan. The active pallbearers were Messrs. Josias Jenkins, George Edward Jenkins Shriver, Alfred J. Tormey, C. Hammond Cromwell, W. Kennedy Boone, J. Ramsay Barry and Alfred Jenkins Shriver.

John Prentiss Poe, LL.D., Esq., Professor of Pleading, Practice, Evidence, Damages and the Law of Torts; Dean of the Faculty of the School of Law; Secretary of the Board of Regents, and member of the University Council for the School of Law, died at the home of his daughter, Mrs. Alfred Tyler, at Ruxton, Md., Thursday morning, October 14, 1909, of paralysis, with which affection he had been stricken the previous Sunday, aged 73.

By the death of Mr. Poe the bar of Baltimore looses a most picturesque and noted figure; the State of Maryland one of its most distinguished authors, and the University of Maryland a most valued counselor. The activities of Mr. Poe were manifold, lecturer, author of legal books and political platforms, politician, after-dinner speaker, teacher, member of public-service boards, lawyer and indefatigable worker, and, above all, a public-spirited citizen.

Mr. Poe was born in Baltimore on August 22, 1836. He was 73 years old. His father was the late Neilson Poe, who was also a distinguished lawyer and author. His mother was Mrs. Josephine Emily Poe. Two of his brothers are still living—Neilson and Charles Poe. He was a second cousin by blood relation and a nephew by

marriage of Edgar Allan Poe, the author and poet. Mr. Poe was educated at Professor Boussard's English and French School in Baltimore, and at Princeton, graduating from the last-named institution in 1854, at the age of 17 years. He entered Princeton in 1852 as a junior. Upon his return to Baltimore he secured a position as a bank clerk, devoting his spare time to the study of law under his father. He was admitted to the bar in 1857. Shortly after his admission to the bar he was appointed law librarian. After the war between the States he was associated with the late Gen. Bradley T. Johnson in the practice of law, the style of the firm being Johnson & Poe.

In 1871 Mr. Poe was appointed a member of the City School Board, and served in that capacity for 17 years. He took a deep interest in the public schools and was instrumental in producing many reforms. During the administration of Mayor Whyte, 1882-84, Mr. Poe was City Counsellor. In 1885 he was appointed president of the City Tax Commission.

In 1889 Mr. Poe was elected as a Democrat in the Second District to the State Senate to fill the unexpired term of Senator C. Ridgely Goodwin.

In 1891 Mr. Poe was nominated by the Democratic State Convention for Attorney-General, and was elected.

In 1857 he received the degree of M.A. from Princeton, and in 1904 was honored by his alma mater with the degree of LL.D.

In 1863 he married Miss Alice J. Hough. Besides his widow, he leaves nine children— Messrs. S. Johnson Poe, who was associated with his father; Edgar A. Poe, City Solicitor; John P. Poe, Jr.; Arthur Poe of Cedar Rapids, Iowa; Neilson Poe, and Gresham Poe, and Mrs. Alfred Tyler, Mrs. S. N. Duer and Miss Margaret Poe.

MARRIAGES

Dr. Frank Owington Rogers, class of 1901, physician and surgeon; secretary and treasurer of Cabarrus County Medical Society, and Health Officer of Concord, N. C., one of the most popular members of his class and an athlete of note, was married Tuesday, October 26, 1909, at Galveston, Texas, to Miss Emma Antoinette Tillar, daughter of Mr. and Mrs. Frank Tillar of that city.

Dr. Rogers is a native of North Carolina, and was born October 21, 1876. He is a son of the late B. F. Rogers and Mrs. Mattie Harkey Rogers.

Dr. Nathanie Burwell, class of 1907, a practitioner of Shepherdstown, W. Va., and Miss Loraine Turner, daughter of Mr. and Mrs. H. M. Turner, were married October 7, 1909, at the home of the bride by Reverend C. H. Rockey of Waynesboro, Pa. The wedding was attended only by near relatives and a few intimate friends. The bride received many handsome gifts, including silver and furniture from Carter Hall, Va., the ancestral home of the groom's great-grandmother.

Dr. Cleland G. Moore, class of 1909, of North Bend, Neb., was married October 5, 1909, to Miss Emma G. Lewis, daughter of Mr. and Mrs. F. I. Lewis of 1413 McCulloh street, Baltimore, Md. The ceremony was performed by Reverend Edward L. Watson, Strawbridge Methodist Episcopal Church, Park place and Wilson street. Immediately after the ceremony Dr. and Mrs. Moore left for North Bend, where they will reside.

Mrs. Moore is the third of sisters to marry physicians, and, strange to relate, the other two picked University of Maryland men as their helpmates; namely, Mrs. Tilghman B. Marden, wife of the Professor of Bacteriology in the Baltimore Medical College, and Mrs. M. R. Bruin, whose husband is a well-known surgeon of Strasburg, Va.

Dr. S. Luther Bare, class of 1905, of Westminster, Md., was married September 22, 1909, at Grace Lutheran Church, Westminster, by Reverend P. H. Miller, the pastor, to Miss Nellie Ruth Schaeffer. The bride is the daughter of Mr. and Mrs. George R. Schaeffer, and the groom is a son of the late David B. Bare. Dr. Bare was a member of the class of 1905, and took a great interest in class affairs. He was very popular during his school days and liked by everyone. The BULLETIN extends to Dr. Bare its well wishes.

Dr. James Knox Insley, class of 1908, was married Saturday, September 18, 1909, to Miss Helen Horn, daughter of Dr. and Mrs. George L. Horn.

Charles C. Harris, D.D.S. and M.D., class of 1883, a member of the dental profession and son of Prof. James H. Harris of the Dental Faculty, was married to Miss Oletia Gordon, near Paris, July 5, 1909.

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PLACENTA PREVIA CENTRALIS IN THE PRIMIPARA, AND REPORT OF ONE CASE.

By A. ALDRIDGE MATTHEWS, M.D.,

Surgeon St. Luke's Hospital, Spokane, Wash.

Placenta previa is a condition which has been known of for about the past 200 years. About that time Portal and a little later Schacher wrote and described the condition quite accurately, but from that time until the time of Barnes no advance was made. Since then the condition has been written upon very extensively, and within the past two years there have been quite a number of splendid articles on this subject published.

In a typical case of normal pregnancy the situation of the normal placenta should be in the upper part of the uterus, above the so-called equatorial zone, and just below the opening of the fallopian tube. It may be attached even to the anterior or posterior walls or to the fundus, the former being the more common. We know, however, that in a certain number of these cases this specific attachment does not occur, the ovum being implanted in the lower uterine segment, where it becomes a distinct anomaly and under the name of placenta previa offering one of the most serious complications both for mother and child with which the obstetrical surgeon has to deal.

The various divisions which the obstetricians divide the placenta previa into are placenta centralis, lateral or partial and marginal. I shall not take up a description of these divisions, but I wish to take up the subject of placenta previa in the primipara, this being a rare complication in pregnancy.

As to the etiology of placenta previa little is known, but we do know that it is from four to six times more common in the multipara than in the primipara. Clinical observers show that chronic inflammation or congestion predisposes to this condition.

Dr. Hirst, in quoting Hoffmeir and Kaltenbach, furnished the best explanation for the abnormal situation of the placenta. These observers have demonstrated by the examination of young ova that the corion villi in the lower pole of the ovum may develop in an hypertrophied decidua reflexa, thus carrying the placenta down to and across the internal os, at first an adhesion between the decidua vera and the reflexa is prevented by catarrhal discharge, but as the ovum develops the reflexa may adhere to the vera, thus fixing the placenta in its abnormal situation, permitting its continued growth and giving rise to an apparent hypertrophy of the decidua serotina.

I think I am perfectly right in saying that all of the American authors are of the opinion that where there is a primipara with placenta previa centralis past the thirtieth week of gestation, with a rigid cervix, that the best and most conservative treatment is an abdominal Cæsarean section, both on account of the mother as well as the child.

Quoting Dr. De Lee: "In 59 cases of placenta previa treated by us three women died. One died of sepsis; she had been tamponed by a midwife at intervals for six weeks. One died of rupture of the uterus, the rupture having been produced by strong traction on a colpeurynter, combined with powerful pains which the traction evoked. One died of hemorrhage from a uterine tear produced spontaneously. This last patient presented evidence of a hemophilic tendency, a large bloody infiltration developing in the left labium and extending up into the abdomen. We take issue with Zweifel on the question of abdominal Cæsarean section in placenta previa. In the case of central previa, with a close os at or near term, we would surely perform the abdominal delivery. Baxton Hick's version, with subsequent spontaneous delivery, is the method of choice when the facilities are not at hand for laparotomy. We always have felt there is a field for Cæsarean section in placenta previa, in spite of Zweifel, Bumm, Schavata, Ehrenfest, Holmes and others, but the selection of

the cases will always be a personal one not guarded by general and accepted principles in treatment."

There is still great diversity of opinion as to the treatment of placenta previa, and these conditions have to be governed by the surroundings in each case; for instance, the condition of the mother, the condition of the child, the surrounding conditions, and last, but not least, the ability of the physician in attendance.

If the mother's condition is good, she has not lost much blood. The cervix soft, which is usually the case in placenta previa centralis, the dilation could be done by the rubber bag and the Baxton Hicks version done as early as the cervix will permit.

The packing of the vagina is recommended by some, and kept packed firmly until the cervix has had a chance to dilate, and if necessary these packings should be changed, although there is considerable danger of hemorrhage back of the packing; therefore, these cases should be watched very carefully, and, too, every antiseptic precaution possible should be taken where the tamponing method is used, for they are especially likely to be followed by infection if our technique is not good, and even sometimes after every precaution. These cases, on account of the great seriousness, should be always, when possible, attended at a hospital, where we have every convenience to meet the many emergencies which might and are likely to arise. After making the diagnosis we should determine the condition of the child, and if in good condition and close to term, every effort should be made to save both mother and child, but if both mother's and child's condition are serious, every effort should be exerted toward the saving of the mother, even though in so doing we may sacrifice the child, for the chances are exceedingly small at the best for the child. So many of these cases are premature, and even if born alive often do not survive, and, too, if there has been much hemorrhage the chances for the child living are very slight, and I think I am justified in saying that if the pregnancy is not further along than the thirtieth week the child should be absolutely regarded as a secondary consideration, and every effort be made to care for and save the mother. The surrounding conditions will govern very much the mode of treatment of these cases, such as conveniences, help, etc., and where such conditions are not good and the proper help cannot be had, it is far better to attempt delivery by the Braxton Hicks method rather than resorting to the abdominal method, for I consider when not in especially well-trained hands this class of work would be safer for the mother to be delivered per vagina and hope that she will be one of the small percentages that will recover under such conditions.

The physicians, of course, vary as to their ability, as there are very few good operating obstetricians in the general profession, to which I myself do not lay any special claim, and in these cases if an expert can be had it is far better for both the mother and child, for the general man naturally would not come in contact with these cases very often, and surely not sufficiently often to make him very familiar with this class of work. If the case is close to term, and the conditions will warrant it, better results could be had by doing abdominal Cæsarean section by a man accustomed to doing general surgery, if an expert obstetrician cannot be had.

Coming, now, to the relative frequency of the condition, different authors estimate it to occurring with rather wide limits. Thus Mueller, whose statistics are based on 876,432 labors, show placenta previa to have been present in the proportion of 1 to 1078, Lomer 1 to 733, Tarnier 1 to 207, Williams 1 to 1000. McPherson, in an article from the Lying In Hospital of New York, states that there were 250 cases of placenta previa in 5200 births, which gives a ration 1 to 208. Those closely approximate the figures of Tarnier. Dr. McPherson further reports that out of 250 cases of placenta previa which occurred in primipara with a ratio of 10.66 per cent., leaving a percentage of 89.43 per cent. for the multipara; of the multipara those twice pregnant were in the majority, and thereafter up to the sixth pregnancy the even number showed a greater per cent. than did the odd, although it was on a decreasing scale.

As to the treatment of placenta previa, when we think of the mortality it makes the physician who who is unfortunate enough to have these cases quake, for the prognosis is always serious. Dr. Hirst gives a mortality of 40 per cent. for the mother and over 50 per cent. for the child. Williams in quoting Mueller gives the mortality from 36 to 40 per cent. for the mother and 66 per cent. for the child.

The foremost and most usual method of treatment by the men who have had the largest obstetrical experience and who are unquestionably the best qualified to determine the best procedure in

these cases, are as a whole opposed to abdominal Cæsarean section for complete placenta previa except in carefully selected cases. Newell quotes Hirst that in the hands of the general practitioner a mortality of approximately 40 per cent. in complete placenta previa, but believes in the hands of experts the ordinary mortality should be reduced close to 1 per cent. The maternal mortality in abdominal Cæsarean section has been variously given up to about 20 per cent.; therefore, when not in the hands of an expert obstetrician and a good surgeon can be had, I should strongly favor abdominal Cæsarean section, as the mortality is about one-half as great as when treated in the hands of the general man. I am of the opinion that the time will come when the abdominal Cæesarean section will be the operation of preference. I do not see why the mortality of abdominal Cæsarean section should be so high. I was of the opinion that it was much lower. I have only been associated in two other cases for abdominal Cæsarean section, both of which made uneventful recoveries for mother and child. It is very true that many of these cases are in the extremest before the surgeon or obstetrician sees them, usually suffering from acute anemia due to the loss of blood, and that perhaps accounts for the high mortality in these cases which I before alluded to.

In quoting Dr. Charles Jewett he reports 2010 cases of placenta previa from German, French and Italian literature in the last few years. The maternal mortality under the obstetrician method of delivery of 221 cases was 10.9 per cent., the fetal mortality of 1159 was 57.3 per cent.; 726 of these cases reported by Feuth were collected from the practice of midwives and general practitioners; many were subjected to prolonged tamponing and were exhausted by needless hemorrhage; exclusive of Feuth's cases the maternal mortality was 6 per cent. plus, and the fetal 68.8 per cent.

Comparing these results with 95 abdominal Cæsarean operations, collected from seven publications, all but one of the last year, the writer finds in the latter a mortality of 11.5 per cent. for the mother and 34 per cent. for the child. The principal danger to be overcome by the abdominal Cæsarean section method is hemorrhage, laceration of the uterus, sepsis, and also reducing the fetal mortality.

Another question can very readily be raised, and that is, Are we justified in sterilizing these women? I emphatically would say no, although there are many men of the reverse opinion who say that when consent of the husband and mother can be had it is a perfectly justifiable procedure. Hofermeyer, J. O. Polak, E. W. Cushion, H. D. Fry, Charles Jewett, M. L. Baldy, J. W. Bovee and others are of this opinion, while Chas. W. Greene of Boston claims that it is not ethical and is morally unjustifiable to sterilize a woman when performing abdominal Cæsarean section, even if she and her husband request it, for she may have children again, and even born normally, and if not normally could be delivered just as successfully by an abdominal Cæsarean section the second time as the first, and if such a request is made and acceded to, not only is the operation morally wrong, but in the event of second marriage it may be bitterly regretted.

Dr. W. E. Ford is of the opinion that sterilization should not be done.

Then the question arises as to the best treatment to be followed in later confinements after a Cæsarean section has been done. I can see no reason why a woman should not deliver herself perfectly normally, although there is a possibility of the uterus rupturing, but I think all women should be given a chance to deliver themselves, but should be watched very closely during labor, for there is danger of the old scar being torn through by the severe muscular contraction which takes place, and for that reason she should always be confined in a hospital, where, if such should happen, immediate assistance could be given her.

Dr. Garrety concludes from his analysis of the literature on this subject that the obstetrician should aim to perform the later Cæsarean section as near to term as possible, and yet before commencement of labor; with the onset of labor there is danger of rupture of the old cicatrix. There are usually scar changes and adhesions requiring modification of the classic technique, but the literature does not show that the prognosis has been aggravated by them. Four, and even five successive Cæsarean operations have been performed in a few cases. The question whether to remove or merely incise the uterus in a later pregnancy must be determined by the strength of the uterine wall. If it shows signs of weakness or cicatricial tissue requires resection, hysterectomy rather than Cæsarean section may be advocated for fear of rupture in later pregnancy. Adhesions which it is impossible to separate is another argument in favor of rendering the woman sterile; therefore,

preferably by resecting and ligating the two tubes hysterectomy is not deemed advisable. I also wish here to submit several personal communications:

Dr. J. C. Webster, Chicago, October 7, 1909:

"I am gradually coming to believe that abdominal Cæsarean section (if the patient be in the hands of an expert operator) will come to be regarded as the wisest procedure in placenta previa in a primipara near term. Non-dilatation of the cervix and lower uterine segment is a most important factor in its procedure, more over the retraction and contraction of the uterus following removal of the ovum effectually checks bleeding. I have once performed vaginal Cæsarean section for placenta previa, but shall not employ it again for this purpose. Ordinarily, I have used the Braxton Hicks bipolar version to bring down a lower limb, which acts as a plug and a dilator to the cervix."

Dr. Barton Cook Hirst, Philadelphia, October 2, 1909:

"If the woman is well developed, the cervix elastic and somewhat patulous, I prefer the induction of labor by hydrostatic dilatation of the cervix, the performance of pedalic version and slow extraction of the infant. If there is any complicating factor, however, Cæsarean section will give the best result for both mother and child in the hands of a trained abdominal surgeon."

Dr. J. Whitridge Williams, Baltimore, October 2, 1909:

"I have had comparatively little experience with placenta previa in primipara, and thus far have delivered all of them by natural passage. My views as to the treatment in this class of cases are as follows: The use of the rubber baloon in all cases in which the cervix is sufficiently softened and dilated to permit its introduction. The rare cases in which the cervix is hard and apparently undilatable would appear to offer a limited field for either vaginal or abdominal Cæsarean section. As, however, the cervix is nearly always softened in case of placenta previa, such an indication can, I believe, arise but rarely, and therefore the employment of Cæsarean section will have a very restricted field."

Dr. L. M. Allen, Baltimore, October 13, 1909:

"My ideas concerning the treatment of placenta previa in the primipara is, as soon as a positive diagnosis is made, empty the uterus. Of course, the method to be used depends upon the conditions in the particular case. In the case of a primipara, cervix intact, complete placenta previa, I believe abdominal Cæsarean section will give the best results. If it is the lateral or marginal variety, hemorrhage slight, the induction of labor by the introduction of bougies and vaginal tampoon, or simply by rupturing the membranes is probably better. In a multipara in whom the cervix is soft and dilatable, slight manual dilation, followed by rapid version and slow extraction, having thigh, etc., act as wedge. If the placenta is not obstructing the entrance into the uterus, often rupture of membranes will remedy the whole thing."

Also I received two other communications from Dr. De Lee of Chicago and Dr. McPherson of New York, both referring me to articles which they had previously written and to which I allude in my paper.

I wish here to submit a case which I think will be of interest:

Mrs. G., white; female; married; occupation, housewife; age, 24; family and past history negative.

Since the beginning of her pregnancy she has had splendid health, not even being annoyed with the ordinary inconveniences of early pregnancy. She has led a very active outdoor life, walking long distances almost every day. At about the end of the thirty-fourth week of pregnancy, upon awakening she noticed a feeling of moisture, and upon examining herself found that she was in a pool of blood, the approximate loss being about four ounces. The bleeding continued for a short while after awakening. I was immediately summoned, and found that the bleeding had ceased. She had not suffered any shock from the hemorrhage, having been lying perfectly quiet since her awakening. Upon examining her I found that the fetal heart sound was good and strong, and upon a vaginal examination found the cervix rigid and hard, dilated sufficiently to admit the tip of my index finger, through which I could feel a rough granular soft mass. Symmetrically around the cervix and the lower uterus I could feel a thick, doughy-feeling substance between the hand and presenting part. I had her immediately transferred to St. Luke's Hospital, where I had a constant attending nurse watching for further hemorrhage. She did not bleed again until the next morning, 24 hours later, and then only a small quantity. I appreciate now that I should not have waited until the next day, but should have operated the morning of the first hemorrhage, for we

can never tell what the next will be, whether mild, severe, or even fatal. The only operation I considered in this case was an abdominal Cæsarean section, for the reason she was a primipara having a firm rigid cervix, a small vagina and placenta centralis. I also deemed it a much safer procedure for the mother than if the Braxton Hicks method were used, and if I had used such method I feel certain that I would have lost the child. The vaginal Cæsarean section I did not consider, as not being familiar with it except from reading and seeing considerable number of criticisms in regard to this operation, although it is highly recommended by many German writers.

Operation.—Patient's abdomen was thoroughly prepared, also genitalia, a 1-5000 bichloride douche being given, patient anæsthetized and ether being used as the anesthesia. A long incision was made through the linea-alba, the belly wall being very thin, the uterus was delivered, gauze and sterile towels being packed around between the uterus and abdominal wall and a vertical incision made through the uterus down to the membrane, which were then broken, a leg seized and the child lifted out of the uterus, cord clamped and cut. The placenta was centrally located over the cervix, peeled off very readily and the uterus was sewed up with chromic catgut. The hemorrhage was very small, being very much less than is lost usually at normal labor. My assistant caught the uterus close down around the cervix and held it firmly enough to prevent bleeding until after the placenta was removed. This, I think, was unnecessary, for I do not think there would have been any excessive hemorrhage. The abdomen was rapidly closed, and before removing the patient from the operating table I examined the cervix, found it dilated to about the size of a quarter of a dollar, and still very rigid and hard. The patient made an uneventful recovery, leaving the hospital on the eighteenth day. The child weighed six and three-quarter pounds. Both have since done splendidly up to the present date.

Dr. Gordon Wilson of the University of Maryland delivered an interesting address at the recent meeting of the Baltimore County Medical Society on the treatment of pulmonary tuberculosis. Among those present who discussed the paper were Drs. Joseph Gichner, R. C. Massenburg, Josiah S. Brown and F. W. Janney.

THE NEGLECT OF THERAPEUTICS.

By C. W. Mitchell, M.D.,
Professor of Medicine and Diseases of Children, University of Maryland.

The relative neglect of therapeutics is one of the reproaches of modern medicine. Compared with the advance in all other branches of medicine, therapeutic progress has, indeed, been slow. The master minds in medicine have been almost solely concerned with the science, and have cared little or nothing for the art of healing. The pride begotten of scientific attainment has, as it were, blinded the eye of the physician to the real purpose of his calling, and he becomes so wrapped up in the means as to lose sight of the end. This attitude on the part of the profession has naturally brought about changes in the relative positions occupied by the physician and layman. The field of therapeutics is the only common ground upon which both stand, and the further removed from that ground the profession becomes, the greater the gap separating it from the public at large. Dr. C. G. Kerley aptly says:

"The time when a physician can make a diagnosis and cease his interest in the treatment of a case has passed. The faith of humanity in curative agents is remarkable, and when the desired end is not reached by the first physician, some other physician is called, and when he fails the next resort is usually the charlatan and the proprietary and patent medicines. The prosperity of the irregular schools of various cults and sciences supposedly healing in character, and the consumption by the people of millions of dollars' worth of useless proprietary and patent drugs are to be attributed in a large degree to an indifferent application of therapeutic measures on the part of otherwise well-qualified medical men. A few great teachers of medicine have done incalculable harm by precept and example in their attitude toward therapeutics."

Then, too, many sociological tendencies of the day serve to loosen the strong tie existing between patient and physician. The growth of specialism and the corresponding passing of the old family doctor tend to lessen the loyalty of the layman to his physician, because of the lack of that individual interest and sympathy which every patient claims as his right. However he may be imbued with the spirit of the modern industrial epoch, however

firm a believer in organization, however in his life's work he may belittle the individual and exalt the multitude, the sick man of today, as ever, remains intensely individualistic, and the weakened hold that the doctor has upon the sick man is largely due to the fact that the glamor of the brilliant successes of surgery, preventive medicine and educational crusades has distorted the vision of the medical man and dulled his keen perception of responsibility toward the sick individual. But, you object, education of the people will solve this problem. Education can never blunt a man's perception of his own physical suffering. A man with toothache is never noted for his altruism.

When a man becomes a patient theories disappear and conditions occupy the center of the stage. Popular education does not alter this fact, but rather emphasizes it. It is under the very shadow of the oldest and greatest university of this country, in the city of the highest average civic intelligence, where public and charity practice are most efficiently organized, that we behold today the most remarkable spread of cultism. Boston is the veritable home of Christian Science and the birthplace of the Emmanuel Movement. But, you say, these are mere fads of the hour, and will soon fade away. Properly interpreted, they are only expressions of the eternal struggle of humanity for respite from suffering, and the loudness of the present cry only emphasizes the failure of the medical profession to adequately meet conditions as they exist today. It is plainly the duty of the profession not to deride these movements, or to belittle their significance, but to honestly call itself to account. It is our duty to examine the causes of the present discontent, to ask how far we are responsible for it and what we can do to relieve it.

Partial answers to the above questions are to be found as follows:

First.—Therapeutic indifference on the part of great leaders in medical progress.

Second.—Careless, unsystematic and improperly individualized instruction to medical students. "Prescription writing is a lost art" is a most trite but very true remark. Students are not taught. Great mergers in the drug business, as in the world of high finance, have swallowed up the small competitor, and pills are not rolled out by hand, singly, but turned out by the million from the machine. The doctor has lost touch with the very tools of his trade, and therefore cannot be expected to construct their finished product. The manufacturing chemist comes along to conjole the practitioner into the belief that his particular preparation has some peculiar properties which could not possibly be reproduced by any combination the doctor himself might make. The groping after the mysterious in medicine is not limited to the laity, and after a while the doctor finally surrenders and always orders C. & N.'s anti-opsonic blood builder because it gives results not achieved by the preparations of any other house. Thus is medicine practiced, and the doctor merges the individuality of the patient, his lessons and symptoms into those of the countless thousands for whom the preparation is made, his grip upon his patient gradually relaxes, until the despairing victim of disease, finally escaping, seeks and often finds relief in the protecting arms of a cult which has its foundation upon the individuality of the patient.

PLAN FOR INSTRUCTION IN THERAPEUTICS.

Instruction should be obligatory upon all students of the third and fourth years.

Pharmacological work not adapted to most students, because apt to be misleading.

The experiments ordinarily performed in the physiological laboratory are sufficient for many of the most important drugs.

During the third year didactic lectures by a clinician should be delivered upon about 30 representative drugs, following a physiological classification. (Pharmacopeia and Physician.) Great stress should be laid upon the physiological actions of the drugs upon man, because confusion is produced by too frequent reference to effects upon animals. No drugs should be dismissed without full discussion of the minor and remote effects, as well as of the important and prompt ones.

Following description in the physiological action and logically and directly deduced from such effects, the therapeutic applications should be taught. It is only in this way that a rational foundation for prescribing can be laid.

At each lecture parallel columns should be written on the board indicating the actions and uses, and there should always be included the writing of a prescription for some imaginary individual.

During the fourth year all groups for ward and dispensary instruction should be taught practical, individualized therapeutics, and every clinical lecture or conference should embrace prescription

writing by the students, together with a general discussion of the treatment of the disease seen. Whenever possible the United States Formulary should be used.

Third.—The presence among practitioners of thousands of poorly-educated, badly-equipped men posing as specialists has done much to lessen the respect for and confidence in the profession felt by the public at large. Men just out of college, without any good general training either in public or private practice, aspire to all the privileges and emoluments of specialists. Their demands upon the profession and the public are ofttimes unbearable. They cry aloud for positions on the teaching staff of our schools and for fat fees from the public. Their rampant commercialism destroys the faith of the public in the entire medical profession, and the narrowness of their medical horizon often renders their therapeutic efforts not only useless, but positively harmful to their unfortunate patients.

This evil is a growing one, and the responsibility for correcting it rests upon all of us. I believe it can be met by enlarging the powers of licensing boards. I am convinced that the time will come when special licenses must be obtained to practice specialties, licenses which shall only be granted to those who, after proper post-graduate instruction, shall be able to show by examination, written and practical, proficiency in the special work which they select to follow. It is unjust to demand of the public special remuneration unless special or truly expert service be rendered.

Lastly, the complexity of modern social life, with the increasingly great prevalence of mental and nervous affections, makes it, in my opinion, necessary that all medical men should receive proper instruction in psychology. It is the woeful ignorance of the profession concerning this branch that has given the greatest impetus to the growth of Christian Science and the Emmanuel Movement. I have no confidence in the neurologist or psychiatrist of today who is untrained in psychology, and I hope soon to see the time when courses in psychology will be obligatory upon all students of medical colleges.

The patrons of Christian Science and the devotees of the Emmanuel Movement will return to the medical profession, where they belong, only when the profession has demonstrated its ability to properly care for them.

HYGIENE OF INFANCY.

By Nathan Winslow, M.D.

After the umbilical cord has been tied the baby is handed to a nurse, who should not only wrap it in blankets, but also carry it into a warm room; for immediately after delivery the child, especially if premature or delicate, has great difficulty in maintaining its animal heat at the proper point. Quite a number of children develop, from a lack of observing these simple precautions, coryza. As soon as possible mop the mouth out with little pledgets of absorbent cotton, in order to get rid of the mucus, but be careful not to destroy any of its epithelium. The child should now be thoroughly greased or oiled, in order to facilitate the removal of the vernix caseosa. The little one's eyes, after having been cleansed with a soft cloth, are protected with absorbent cotton, in order to prevent any water from running into them whilst the rest of the face is being washed. After these preliminary procedures the infant is immersed in a bath of a temperature of 100 degrees, so as to remove the vernix. If the mother has any purulent vaginal discharge, it is well to employ Crede's prophylactic method of washing the conjunctival sacs out with a drop or two of a 2 per cent. solution of silver nitrate. After the tubbing the obstetrician should carefully inspect the babe to see if it is normal, or if it has received any injuries during labor. He should examine the shape of the head, the body, the anus, and note any abnormality of the genitalia, for a tight, adherent prepuce in the male is conducive to a great many of the nervous symptoms of early childhood. If all is well, the stump of the cord is dressed with sterile gauze and cotton, just as any other open wound is treated. Some, however, prefer to dust the remnant of the cord with 1 part of salicylic acid to 19 parts of starch, and then to cover it with absorbent cotton, but the former method is preferable. Now the child may be dressed, placed in its crib in a darkened room and covered with blankets. If there are any signs of imperfect circulation, the feet should be wrapped in flannel and hot-water bags put in the crib. After six hours the child is put to the breast, so as to develop the nipple and to encourage proper nursing habits.

After the initial bath the child should be washed daily, but should not be immersed in the tub until the stump of the cord has sloughed off and the

umbilicus has entirely healed. After this a bath should be given at least once daily throughout infancy. The temperature of the water should be about 98 degrees for the first few months. Not until the head has been wet should the child be immersed in the water, and then it should not be allowed to remain in the tub more than a minute and a half. During the first six months the tubbing temperature should be gradually reduced to 95 degrees. At one year the temperature may be lowered to 90 degrees. By the time the child is a year and a half old it should be able to stand a temperature of 85 degrees, and at the end of the second year the temperature of the water ought to be down to 80 degrees. During the third year it is well to accustom the child either to cold plunges or shower baths of 70 degrees, the immersion lasting from 30 seconds to one minute. After taking out, rub the child with coarse towels. The carrying out of this plan will greatly diminish the susceptibility of the child to taking cold, and will enable it to better withstand the changes of temperature. When a child fails to react, as manifested by its shivering and the cyanotic hue of its skin when taken out of the tub, do not persist, but raise the temperature of the water. For purposes of cleanliness the warm bath given at night is the best, but for purposes of gymnastics the cold given in the morning. You can combine the two by giving the warm and topping off with the cold. The bath is not only useful for purposes of cleanliness, but it also has therapeutical value. Fevers can often be warded off by the graduated bath, in which case the baby is immersed at 90 degrees and the water gradually reduced to 75 degrees. Again, we find it a very efficacious agent in contagious fevers not only for its antipyretic effects, but also for its property of allaying delirium. Moreover, it not only tones up the circulatory system in cases of sluggishness or congestion of the pulmonary circulation occurring in such diseases as measles, varicella, etc., but it also acts as a respiratory stimulant, owing to its shock to the nervous system. Hot baths may be advantageously employed in convulsions due to rickets or chorea.

Among the very poor the children are overdressed. On the other hand, in order to make a grand display, among the very rich, underclad. It is essential to the welfare and the proper development of the child that his clothing should be not only loose, but also should exert no pressure upon any portion of the body. Bands should not be pinned so tightly about the trunk as to embarrass the movements either of the chest or abdomen. The baby's wardrobe should contain the following articles: Abdominal binders, undershirts, napkins, flannel petticoats and dresses. The belly-band serves the purpose of protecting the intestines and of acting as a support to the abdominal wall. If sufficient adipose tissue is present in the abdominal walls it may be discarded after the third or fourth month. The chest should be covered with a knitted woolen undershirt, high in the neck and with long sleeves. The napkins ought to be made of some soft, absorbable material. This article of dress should be changed as soon as soiled, else the skin of the child will become inflamed and excoriated. Under no circumstance except upon railroad journeys is it permissible to employ rubber napkins. Do not permit the petticoats to be supported by waistbands, but instruct the parents to have them suspended by straps from the shoulders. The dress, the last article needed to complete the trousseau, and the petticoat should extend some distance below the feet, in order to keep them warm. All articles of clothing should be buttoned on the back. These are all the garments needed by the child when indoors, but when baby goes out it should be better protected. Shoes and stockings, as they are soiled so often, are not necessary indoors until the child commences to walk, but should be added to his other clothing when he goes out for an airing.

The night clothing of infants should be as loose as possible, and should be made of the lightest flannel. The common mistake is to overload babies with covering at night, which is the explanation of much of the restless sleep. In older children, where there is a tendency to expose the feet, the night clothes should consist of a union suit with waist and trousers with feet.

During exercise the movements of the child should in no way be interfered with by its clothes. It obtains its exercise by crying, kicking and numerous other movements. If baby is allowed to lie immovable in its crib it gradually fails to increase in weight, then after a while there is a loss of weight, its cry becomes weak, anorexia follows, and after a while there is indigestion. In order to prevent this sad state of affairs, we should make it our duty to carefully instruct the nurse to frequently change the position of the infant.

The very best evidence of what a child ought to do is what it does. It begins to hold its head up at

the time that the muscles of the neck permit, and it makes no endeavor to stand until the muscles of the lower extremity are properly developed. An ordinary child will commence to crawl about the fourth month.

A child left to itself will make no efforts to muscular exertion of which it is incapable, so when it shows a desire to crawl or walk let it alone, and it will get all the exercise it needs. Walking should be spontaneous, and the cause of genu valgum is rickets. Generally speaking, premature walking does not affect the legs.

When the child becomes older see that it gets enough outdoor exercise. We should encourage it to play ball, to ride bicycles, to run, to swim, to row, to skate and to indulge in all manly sports. The two sexes at this period should associate with each other as much as possible.

In warm weather any healthy baby one week old, if its face and eyes are properly protected from the sun and wind, can be safely taken outdoors. If born in winter, postpone this event, but a hearty youngster after one month of age, weather permitting, if properly dressed, can be taken in the open air. Even 20 degrees F. in clear weather is no contraindication to this procedure. As a rule, every child should spend two or three hours on the street, and the only contraindications to this out-of-door airing are rain, high winds, damp weather and low temperature. In case of continued bad weather, or when the mother is afraid to allow her baby to go out because the mercury is below the freezing point, insist upon a constitutional airing. In this case it is well to remember that we can obtain some of the effects of an outing by taking the child, clad as if it were going out, from the nursery into another room. Then open all the windows and parade the child up and down.

Sleep is one of the most vexatious questions with which we have to deal in the management of infants, yet there are some general rules which are laid down for our guidance. It is not wise to permit the new-born to sleep in the same bed with its mother. A child during the first month should be waked every two hours during the day and twice at night; during its second month of existence it should be aroused only once during the night, and after the fourth month it should not be disturbed between the hours of 10 P. M. and 6 A. M. It is bad policy to walk the baby to sleep or to give it sugar-tits, rubber pacifiers and the like to induce sleep, as it may form an unbreakable habit. So as soon as baby is through nursing put it in its crib; a warm bed, dry diapers, a dark, quiet room and its appetite fully satisfied are all the conditions that are necessary to cause the child to sleep. As a child grows older the sleeping hours gradually lessen, and a healthy child at 12 months of age should sleep about 15 hours out of 24—12 at night, 3 in the day divided into two equal parts.

The skin of the infant is very delicate, and great care must be taken to keep it clean, but never use strong soaps for this purpose. When the napkins are wet they should be removed as soon as possible, and all the folds of the skin should be kept dry by dusting them with talcum, stearate of zinc, etc. Sometimes plain water causes irritation; then we resort to the salt or bran baths.

Cleanse the eyes daily with boric-acid solution. It is better at first not to expose them to strong light. At night the child should sleep in a darkened room.

Wash the mouth of the new-born daily for a few weeks. If there is any tendency to thrush, mop the mouth after each feeding with a 4 per cent. solution of boric acid. When the child's teeth appear they should be kept clean, because they are liable to decay if neglected.

The genital organs of the female need little attention. On the other hand, those of the male should be carefully watched. A long foreskin and a small preputial opening demand a circumcision.

After the child has nursed two or three times the physician should inquire of the nurse whether any meconium has been passed. The non-appearance of this substance indicates an atresia somewhere in the digestive tract. Most frequently there is a membranous partition over the anus, which is very thin, and when opened corrects the malformation. On the other hand, if the obstruction is higher up, an inguinal colostomy must be performed, else the child will soon perish. At three months of age a child ought to understand that it is to pass its feces while sitting on a chair made for that purpose. This alone is a great saving to the mother, owing to the great amount of washing otherwise required. The child should be put in its chair as soon as it finishes nursing, and left there until its bowels have moved. Most children of nine or ten months of age can be taught a way to indicate a desire to defecate.

It is much harder to teach the child about pass-

ing its urine, but when it is one year old it should not wet its diaper during the night.

In order to protect the brain, which grows more rapidly during the first two years than at any other period of life, from injury, insist upon freedom from all sounds, sights or stimulations, which call forth shrieks of laughter from the child; for the healthy development of the cerebro-spinal matter demands rest, quiet, peaceful surroundings and absence of any unnecessary excitement. Owing to the numerous functional nervous disturbances in children, it is well for the attending physician to thoroughly instruct the parents in the proper hygiene of the nervous system, and to insist that the infant shall be kept quiet and not played with, especially at night, else harm will result to the child.

The nursery should be a large, airy room, and situated on the second floor. It should be the best-ventilated room in the house, and should, if possible, have a southern exposure, so as to insure adequate sunlight, which element is absolutely indispensable to the welfare and health of the child. The windows should be furnished with light, washable curtains. Free ventilation without draughts is an absolute necessity. This is best accomplished by means of a ventilator made of an elbow of stovepipe and placed in the window. The nursery should be heated by an open fireplace. Wallpaper is an abomination, particularly that of today, which is of a very brilliant color, as it contains arsenic. As a consequence of this constituent quite a number of cases of chronic arsenic poisoning have been reported. The walls should be painted and comparatively bare, and we should dispense with all draperies that are not necessary, as the germs of the infectious diseases find a favorable nidus in these articles. The furniture of the nursery should be as simple as possible. Pictures and moldings are unnecessary, as they furnish a lurking place for pathogenic organisms. Floors covered with rugs or hard polished floors are more to be desired than those protected with carpet, as they can be more easily cleansed. The toys of the baby should be as far as possible indestructible, free from paint and adaptable to his growing muscular needs. If any light is needed at night, the ordinary wax candle is all that is necessary. The best form of heat is the open fireplace, and we should never permit steam heat or a gas stove to be used except for a few minutes in the morning during the bath. The temperature of the nursery during the day should not be over 68 or 70 degrees F., and we should always judge the temperature by the thermometer, and not by our own sensations, or we will be apt to keep the room too hot, and an overheated room is frequently the cause of indigestion and loss of weight. At night during the early months the temperature of the bedroom should not be lower than 65 degrees, but after the first year it may be as low as 55 degrees. When the child is out of the room the windows should be thrown wide open and the room thoroughly aired, and before the child is put to bed the nursery should be well aired.

The advisability of sending the child to school is a very important as well as difficult question to decide. In the first place, a child should never be allowed to attend a school until the danger of that pupil spreading disease has been as far as possible removed; that is, a child should not be allowed to enroll as a pupil until vaccinated. Furthermore, a child who has been exposed to an infectious disease should not be permitted to attend school until the period of incubation of that malady is over.

Again, you should not allow a child to go to school whose hygienic conditions you have not thoroughly investigated, as a very large number of the headaches of childhood is due to poor ventilation. It is evident that a child kept four or five hours in a badly-ventilated room, if exposed to damp or chilly weather when school is let out, may contract a cold or pneumonia.

Before enrolling a pupil his eyesight should be thoroughly examined, for a near-sighted child in a badly-lighted room or in a rear seat has constantly to squint at the figures on the blackboard, thus introducing one of the most powerful factors in the causation of the functional nervous disorders of childhood. It is a bad policy to force the child to continually use the right hand, as he is liable to become round-shouldered. In many of the large cities kindergartens have been introduced. Here the child is made to maintain the erect posture and the ventilation is good. They, however, have this disadvantage, the giving to the child the wrong idea of life, i. e., that life is only for pleasure.

Dr. Charles Benson, son of Dr. Benjamin R. Benson of Cockeysville, Md., has been appointed to the staff of Columbus Hospital, New York. Dr. Benson was until recently a member of the staff of Bayview Hospital.

THE UTERINE CURETTE IS OFTEN A DANGEROUS AND HARMFUL INSTRUMENT.

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

This is an old subject. The dangers and accidents attending the use of the instrument have been written about over and over again. But if it is old and commonplace, and has been written about often, it is not as simple a procedure as it appears. I have seen two accidents that were most distressing, and many others not as serious, due to the faulty use of the instrument. I do not think a curettage under certain conditions a simple operation at all. Now, when the curette is possibly used oftener than any other gynecologic instrument, and used by every physician in active work, it becomes, by the very frequency of its use, a very dangerous and harmful instrument when used injudiciously. The operation of curettage is done for many varying symptoms and conditions. It is done for irregular, frequent and profuse uterine bleeding. When there is a supposed endometritis, curettage is also done, and is probably done oftener for this condition than any other. The diagnosis of an endometritis is erroneously based upon the fact of a leucorrheal discharge. It is the most frequent operation for the cure of painful menstruation. It is often done in a routine way, and without any positive indication whatever.

Before doing a curettage for any condition, a history should be gotten. To get a proper history requires patience, tact and enthusiasm. It cannot be done in a half-hearted way. It is needless to enlarge on the necessity of getting a thorough history. Without such a history there must be frequent errors in diagnosis. For instance: Uterine hemorrhage may be due to an incomplete abortion or an ectopic pregnancy. It would be good judgment to do a curettage for hemorrhage due to an incomplete abortion, but it would be very bad judgment to do a curettage for hemorrhage due to an ectopic pregnancy.

After getting the history, the various organs of the body should be examined, ending with the pelvic organs. I remember many years ago having a patient with frequent and severe uterine hemorrhage. After using various drugs to control the hemorrhage and failing, I did a curettage. It did no good. The woman had a scirrhosis of the liver, and her portal circulation was obstructed. The hemorrhage continued unabated until her death, which occurred several months later. I have had two such cases. So it is necessary to make a general examination of the patient. It is not right to confine our examination to the pelvic organs if we hope to do thorough work. Lastly, the pelvic organs should be examined. One of the accidents alluded to in the first part of this paper occurred because the physician assumed that the uterus was in its normal position of anteversion, and did not make a pelvic examination prior to operation. The woman had been bleeding for several weeks, and he attempted to do a curettage. The dilator was introduced into the uterus by directing its point upward, as is done when the uterus is in anteflexion or anteversion. The uterus was not in anteversion, but was retroverted and adherent. The inevitable result followed, the anterior uterine wall was penetrated and torn and other damage was done, necessitating a laparotomy. The currettage was introduced through the tear in the uterus and the curettage proceeded, when a loop of intestine was brought into view. That is a serious accident. In making the pelvic examination there are a number of other things to be borne in mind. The position of the uterus must be ascertained, and also its size, whether it is movable or adherent, whether it contains myomas, or if there is disease of the adnexa—such as inflammation or neoplasms. I have now sufficiently emphasized the importance of getting a history, of making a general examination of the patient, and lastly of making the pelvic examination before doing a curettage.

Having done that, I shall now attempt to show how the injudicious use of the curette can become dangerous and harmful when used:

First—For Uterine Hemorrhage.—When the hemorrhage is due to an incomplete abortion the finger is the best curette. The curette is capable of great harm in this condition, especially if sepsis is present. The retained tissues can nearly always be detached by the finger, and no harm is done to the uterine walls in using the finger. A curettage done with the finger is intelligently done, and there is no uncertainty as to whether the uterus is clean or not. Nothing is left behind when the finger is used. I have repeatedly re-

moved with the finger bits of placental tissue from uteri which had been previously curetted with the curette. No one can ever be certain that he has removed every particle of tissue from the uterus when the curette is used alone. I sometimes combine the two (the finger and the curette) in removing particles of tissue from the uterus. The specially adherent point is located with the finger, and then the curette is used. A number of years ago I had a very large curette made to be used in cases of incomplete abortion and after labor. In these cases, and especially if there is sepsis present, the uterine wall is very soft and friable and easily damaged, and often punctured by the ordinary sized curette. I am satisfied the curette has been the means of doing much harm in this class of cases; in fact, cases have terminated fatally from repeated curettages, when, if let alone, would have recovered. I have on three occasions punctured the uterine wall with a curette. Fortunately, no harm resulted, but it is not an agreeable experience.

There are other sources of uterine hemorrhage than incomplete abortion. A myoma situated in the uterine wall is often the cause of persistent hemorrhage. The myoma may be very small and easily overlooked. A curettage to arrest hemorrhage from this cause would do no good, and might do much harm. As I am not writing of uterine hemorrhage, but of the danger and harmfulness in the use of the uterine curette, it is not necessary to go more fully into the cause of uterine hemorrhage.

My second subject is Curettage for Endometritis. An acute endometritis should never be curetted. Cullen examined a number of uteri removed by supravaginal hysterectomy for pus tubes, and failed to find a chronic endometritis in any one of the uteri. An acute endometritis seldom ends in a chronic endometritis, but in complete recovery. The leucorrheal discharge, which is so common in women, is oftener due to disease of the cervical mucosa than to the corporeal endometrium; therefore, a curettage seldom arrests this discharge. Amputation of the cervix is the proper procedure in certain cases in my judgment, and not a curettage. Many times this leucorrheal discharge is kept up from inflammatory disease of the tubes and ovaries. Curettage for a gonorrheal endometritis seldom results in a cure. The so-called glandular or hypertrophic endometritis is benefited and cured by a curettage.

My third subject is Curettage for Dysmenorrhea. Curettage for dysmenorrhea seldom, if ever, results in a cure, but frequently in harm. Dysmenorrhea is rarely due to disease of the endometrium, but is oftener due to errors of development of the uterus, poor health and overwork. It is often associated with neurasthenia, and is rarely due to mechanical causes, such as anteflexion and retroflexion. Inflammatory disease of the adnexa and myoma in the uterus are causes of dysmenorrhea. I believe the damage done to the uterine mucosa by the curette in these cases often does more harm than good, and is often the cause of scanty and painful menstruation. If the curette is used at all in these cases, it should be used very gently. I have almost come to the point of discarding the curette in the treatment of dysmenorrhea altogether. The injudicious use of the curette in this class of cases does not harm through injury to the endometrium. It is conceivable when the operation is repeated several times (and that if often the case) and where considerable force is applied to the curette that great damage may and can be done to the musculature of the uterus, as well as to the endometrium. With this changed endometrium, scanty and painful menstruation is sure to occur. Curettage is frequently done in a routine way, and without any positive indication for the operation whatever. This is reprehensible. From a large experience I believe a large percentage of all curettages are useless, and often harmful.

REPORT OF THREE CASES OF PERFORATING ULCERS OF STOMACH, WITH TWO RECOVERIES AND ONE DEATH.

Reported by G. Hampton Richards, M.D.
Assistant Resident Surgeon University Hospital.

Perforating gastric ulcers with recovery are rare. Gastric ulcer so diagnosed is rather common, but, as has been reported in several articles of recent publication, it has been shown that many supposed gastric ulcers at operation prove to be gall-bladder conditions of various kinds.

Case No. 1, which is reported below, had been treated for indigestion for the last 18 months. The man had never been given a test meal nor had the stomach contents ever been examined. This

only proves the old story—someone failed to use all the means of diagnosis available for the proper differentiation of the case.

There are two points which were found in these cases which are not mentioned in textbooks, as far as I remember. They are, first, the red blood which the patients speak of in the stool; second, the general contour of the abdomen—concave in the upper portion and convex in lower.

Case I.—Operated upon by Dr. J. W. Holland, in the service of Prof. J. Holmes Smith.

The patient was admitted to hospital about 12 o'clock midnight, January 9, 1909, complaining of intense pain in his abdomen, which came on about one hour before admittance to the hospital.

Name H. M.; male; colored; age 38 years; height 6 feet 1 inch; weight 151 pounds; occupation, waiter; social condition, married; family history, not important.

Past history: The patient has had very little illness until about one year ago, which his present illness dates back to. He has been a waiter for the past eight years. His meal times have been very irregular, and he would often eat between meals; very often he would taste soups and liquids of various kinds when they were hot. About one year ago he began to suffer with pain and fullness about the stomach. He was treated some time for indigestion, but was not relieved. He has lost about 30 pounds in weight within the last six months. The pain was most severe about one hour after meals, and at times it would cause him to stop work and sit down.

Present illness: About one hour previous to entrance he was sitting down to eat, when he was taken with a violent pain in the upper abdomen, just about the median line, one and a half inches below the ensiform cartilage. He was brought to the hospital in an ambulance and placed in bed.

An examination showed the following: Abdomen very rigid; so much so, one could not palpate deeply at all. The abdomen was concave from the ensiform cartilage to the umbilicus, and convex from this point to the pubes. Tender over the entire right side—more so over the gall bladder region. The patient complained of very severe pain, which was constant. Temperature 97⅗° by mouth, 99⅗° by rectum; pulse 90; respiration 24 per min. Patient's expression very anxious, and the tongue dry, but clean. When an operation was mentioned to the patient he expressed himself as not caring what was done, so he was relieved. Heart and lungs normal. Urine showed nothing of interest. An examination showed the rectum free of hemorrhoids and the mucous membrane normal. Nothing could be palpated in the pelvis by rectal examination. The patient's bowels had not moved for 24 hours. An ice bag was placed over the gall-bladder region, and one ounce of magnesium sulphate was administered; also morphia, and the patient made ready for operation. Seven hours later his bowels did not move. No vomiting. An enema was given, which was not effectual. A second enema was given, with high enema tube inserted well up into the rectum by means of the finger, which was not effectual, and had to be siphoned off. The patient was taken to the operating room, and an incision in the median line of the abdomen, extending from about one inch below the ensiform cartilage to the umbilicus, was made. As soon as the peritoneum was opened gastric contents were found free in the peritoneal cavity; this was sponged out and the stomach exposed. The gall-bladder was found to be adherent to the pyloric end of stomach. There were a great many adhesions about the gall-bladder. These adhesions were broken, and in doing so the gall-bladder was released from the pylorus. This exposed an ulcer about the size of a dime. The ulcer resembled a punched-out hole in the anterior wall of the pylorus very much like a cautery burn.

The ulcer was closed with fine silk sutures. A posterior gastrojejunostomy was performed by means of a Murphy button. The patient was drained by means of rubber tissue tucks, one being placed in the lesser peritoneal cavity. The incision was closed up to the drainage tubes. The patient was placed back in bed, and nothing allowed by mouth for 48 hours, and he was given normal salt solution by the rectum during this 48 hours. He was dressed daily, and the tucks were removed. Patient's temperature did not exceed 100° any time during the illness. About 19 days after the operation he began to have pain in region of stomach, and up to this time he had only been allowed soft diet. As gastric ulcer is generally found in the presence of hyperchlorhydria, and he was not getting sufficient proteids in his diet, he was allowed meats, and his pain disappeared.

He was discharged from hospital after gaining in weight and having no discomfort whatever.

Case II.—Operated upon by Prof. Randolph Winslow.

Patient entered hospital January 2, 1909, complaining of intense pain in upper abdomen.

Male; white; age about 60 years.

Man could not speak English, so his history was very deficient.

Family and past history could not be gotten, and, indeed, only very little could be gotten from patient to aid in diagnosing his case.

An examination showed the following: Heart and lungs practically normal; abdomen concave in upper portion, convex in lower; very rigid and tender; more tender over upper and right quadrant. The mouth was dry and the tongue coated. No history of vomiting. The rectum was distended, but nothing could be palpated. He was advised to be operated on, but refused until next morning, January 3, when he consented. By this time his condition was hopeless. He was prepared in usual aseptic manner. The peritoneal cavity was opened in median line, and found containing gastric contents. This was sponged out, and an ulcer was found situated at the pyloric end of stomach, on the anterior surface. The ulcer was closed, but his condition was such that nothing further could be done. The wound was drained and patient placed in bed. He died a few hours later.

Case III.—Operated upon by Prof. Randolph Winslow.

Patient entered hospital July 31, 1909, complaining of pain in the abdomen.

Male; white; age 50 years; occupation, stevedore; family history, nothing of importance.

Past history: He has had some of the diseases of childhood, but does not know which. He had "malaria" several years ago. He has been suffering with pain in stomach for last two years. This pain was more marked about one hour after meals. He was treated in Pittsburg for "gastritis" for sometime without relief. He later came to this city, and was examined by several physicians, and all pronounced him healthy, and advised him not to pay any attention to the pain in his abdomen. The pain did not cease, but continued to grow worse until July 31, 1909, when he was brought to this hospital.

Present illness: Patient gives following history: Five hours previous to entrance he was taken with a severe pain in the abdomen, in the upper right quadrant and in the median line. This pain was of a very sharp lancinating nature. He had never experienced such attacks, nor had he ever been jaundice. Later the pain was general all over the abdomen. No history of vomiting. His mouth was dry and tongue coated. He had an expression of intense anxiety upon his face. An examination showed the following:

Heart and lungs normal; urine, dark amber color; reaction acid, Sp. Gr. 1032; sugar, negative; albumen, positive, heavy rings; sediment, a few leucocytes and epithelial cells. Ten days later albumen in the urine could not be found.

His abdomen was of same contour as above mentioned, convex in upper portion and concave in lower; very rigid and tender, more tender over the right hypochrondriac region; rectum normal; leucocyte count 13,500; temperature 99⅘°; pulse 105; respiration 50.

The patient was gotten ready for operation at once. An incision was made in the median line extending about two inches above and below the umbilicus and to the right of the same. The peritoneal cavity was opened, and gastric contents were found. There was an ulcer found located on the anterior surface of the pylorus. This was closed with silk, and a posterior gastroenterostomy was performed by means of clamps and silk suture. The peritoneal cavity was well sponged out and drainage placed in upper portion, as well as another opening made over the pubes, and a drainage tube placed in the pelvis.

The patient was placed back in bed and kept in the Fowler position. He was not allowed anything by mouth for 48 hours, when he was then allowed ice and one ounce of water every two hours, which he retained.

The next day he was allowed liquids, and two days later soft diet. He was dressed daily.

For the first 24 hours drainage was profuse. After this there was very little. The tucks of upper abdomen were removed, and later the one from the pelvis. The wound healed very nicely. His temperature never exceeded 101° and pulse 105. The respiration came down to normal soon after operation, and remained so.

Patient was discharged from hospital 15 days from time of entrance cured.

The resident physicians and clinical assistants of the University Hospital gave a ball to the nurses Monday, November 29, 1909, at Albaugh's Theater.

THE PROFESSORS OF SURGERY IN THE UNIVERSITY OF MARYLAND.

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

No. 4.—Nathan Ryno Smith, M.D., LL.D.

Dr. Nathan Ryno Smith was the most distinguished man who has ever occupied the surgical chair in the University of Maryland, with the exception, possibly, of Dr. Wm. Gibson, whose distinction came chiefly after his removal to Philadelphia, where he became professor of surgery in the University of Pennsylvania; but with Dr. Smith it was different, as he achieved his reputation here in Baltimore, whilst the incumbent of the chair of surgery in the University of Maryland, which position he occupied about 50 years. He was born in Cornish, N. H., on the 21st of May, 1797, being the second son of an illustrious father, Dr. Nathan Smith, subsequently professor of medicine and surgery in the Medical School of Yale College. Dr. Nathan R. Smith received his classical education at Yale, where he graduated with the degree of A.B. in 1817. He also pursued his medical studies at Yale College, and received the degree of Doctor of Medicine there in 1823. He first practised at Burlington, Vt., and whilst there assisted in the organization of the medical department of the University of Vermont, at which he was the first professor of anatomy and surgery. He spent the winter of 1825-6 in Philadelphia pursuing studies at the University of Pennsylvania, and became associated with Dr. George McClellan and others in the establishment of Jefferson Medical College, where for two sessions he held the chair of anatomy. Amongst his pupils at Jefferson Medical College were Samuel D. Gross, subsequently the Nestor of the American medical profession, and Washington L. Atlee, who became a renowned surgeon. Upon the resignation of Professor Pattison, Dr. Smith was elected to the chair of surgery in the University of Maryland, a position which, as has been stated, he held for nearly 50 years. He found Baltimore a ripe field for surgical practice, and so thoroughly did he dominate surgical thought and work in this city and State that he became known widely as the Emperor, and to this day those of his pupils who are living still cling to this term. At the time of his removal to Baltimore he was about 30 years of age, and he continued to live here until his death in 1877. During the time of the troubles between the trustees and the faculty of the Medical School he accepted the chair of practice of medicine in Transylvania University at Lexington, Ky., and for three sessions traveled backward and forward to fulfill the duties of his position. He delivered some lectures during this time, however, also at the University of Maryland, and upon the readjustment of the affairs of the University of Maryland he resumed his professorship of surgery, in 1840. In 1867 he visited Europe and became personally acquainted with the most distinguished surgeons of Great Britain and the Continent, by whom he was treated with great respect and attention. "Professor Smith was a man of commanding presence, fully six feet in height, with clean-shaven face, a well-shaped Grecian nose, long, thin, compressed lips, piercing eyes surrounded by shaggy eyebrows, a well-poised head and a long neck concealed by an old-fashioned black stock and standing collar. He was near-sighted, and wore glasses." He lectured without notes, and in slow, deliberate fashion, in a voice of medium pitch, distinct, though not strong. He was an indefatigable worker, and was accustomed to make his rounds at the Baltimore Infirmary, now the University Hospital, about 6.30 o'clock in the morning. Whilst his surgical work was very varied and extensive, his reputation rests chiefly upon his lithotome, an instrument for the performance of lithotomy, and the anterior splint. It is said that he operated for stone in the bladder about 350 times, with a very low mortality, a large portion of his success, as well as that of his son, Dr. Alan P. Smith, in these operations being due to their use of this lithotome. The anterior splint, for the treatment of fractures of the lower extremities, was a great improvement on the methods in vogue at that time, and was considered by Professor Smith to have been his chief contribution to surgery. This splint has now fallen into undeserved disuse, and is as capable now of rendering good service as it was when perfected by him in 1860. The Hodgen splint, which is being used satisfactorily in some parts of this country, is merely a modification of the anterior splint of Dr. Smith, and the usefulness of both of these instruments is due to the fact that the limb can be swung and a certain amount of motion permitted without interfering with the healing process. The principle upon which this was based was that of the

double inclined plane, with suspension. During the Civil War the anterior splint was used with the greatest benefit and comfort in the treatment of soldiers suffering from compound gunshot fractures of the lower extremities. He resigned his chair in the University in 1870, but until his death continued a nominal connection with the school as president of the faculty and emeritus professor of surgery. As has been said by Professor Chew in an address commemorative of Dr. Smith, "he has left behind him the record of a great surgeon, a brave and true citizen, a magnanimous gentleman. Full of years and honors, he rests from a life of arduous and faithful toil." He died on July 3, 1877, aged 80 years. He received the degree of LL.D from Princeton College in 1852. He contributed freely to medical literature, and was the author of several medical works, the most important of which were "Memoirs, Medical and Surgical, of Dr. Nathan Smith," with additions by the author, 1831; "Surgical Anatomy of the Arteries," 1830; "Fractures of the Lower Extremity and Use of Suspensory Apparatus," 1867, and "Legends of the South," 1869. An excellent, handsome and lifelike portrait of Professor Smith adorns the faculty room of the medical school, and also a portrait, taken at a later period of life, is a valuable possession of the Medical and Chirurgical Faculty of Maryland at their hall on Cathedral street.

ABSTRACT OF AN ADDRESS ON THE LIFE OF PROF. HORATIO GATES JAMESON, M.D., CLASS OF 1813.

Delivered by GEN. HORATIO GATES GIBSON, U.S.A.

The following article was compiled from two publications of Henry O. Marcy, A.M., M.D., LL.D., of Boston. They relate to an eminent physician of Baltimore to whose memory, as Dr. Marcy writes, "scant justice has been given." With the exception of Dr. Quinan's book on "The Physicians of Baltimore" and Dr. Cordell's "Medical Annals of Maryland," which I have not yet seen, it would seem that the resurrection of his fame is largely due to the Rev. E. O. Jameson in "The Jamesons of America," and to the sketches of Dr. Henry O. Marcy, both of Boston. Col. J. Thomas Scharf in "The Chronicles of Baltimore" does not even mention his name, although Dr. Jameson held prominent public positions. It is another illustration of the truth of the Scriptural axiom that "a prophet is not without honor save in his own country," and of another that Baltimore, like the rest of the world, "knows nothing of its greatest men."

When a guest at the Maryland Club in 1855, and later, in 1882-83, the old men I met had never even "heard tell of him." I except Mr. Samuel Taggart, who lived near his son in 1855, at Mt. Washington. Had his profession been like mine —that of destroying life instead of saving life— what would have been his modicum of glory?

I am deeply gratified, as his descendant, that Dr. Marcy, who never knew him and lived in a city remote from him, has restored the full measure of my grandsire's fame, of which my native city has reason to be proud, as well as ready to do like honor to him as Washington has done to Hahnemann, of another coterie, and to Benjamin Rush, the first great American physician. If prominent citizens of Boston, which he never visited, and of Philadelphia and New York deem him worthy of all honor, why should those of Baltimore, where he sojourned for nearly half a century, withhold their tribute of appreciation?

The following is compiled from two publications by Henry O. Marcy, A.M., M.D., LL.D., of Boston, Mass.—"A Brief Sketch of One of Baltimore's Greatest Men, Horatio Gates Jameson, M.D.," and "The Suture; Its Place in Surgery" —the latter from *The Journal of the American Medical Association*, January 16, 1909, Vol. LII, pp. 201-208, and the former from *The Transactions of the Southern Surgical and Gynecological Association*, 1906, and after the lapse of 54 years since the death of Dr. Jameson, may be of some interest to the medical and other citizens of Baltimore:

Even Lord Lister of England, a man of wide erudition and research, was entirely ignorant of the work of a predecessor in this field (surgery), to whom now I have the honor of calling your attention. This was the more natural since I suppose today our English friends will admit that they earlier shared with Sidney Smith in the feeling which he expressed when he satirically asked, "Who reads an American book?"

In this goodly city of Baltimore, in the early period, there lived a surgeon who is entitled to monumental distinction and enduring fame—Dr. Horatio Gates Jameson. He was a surgeon of

distinction, although a general practitioner of medicine. His publications were not numerous, as adjudged by a modern standard, but he wrote an admirable treatise upon fevers, a book upon domestic medicine and was the editor of a medical journal for years. His conclusions were quite at variance with the accepted teachings of the day, but in the light of our present knowledge re-read would be considered fundamental and orthodox.

The sources of information of a man so famous are extremely meager, although men still living have him in memory. Our late friend, Dr. Gross of Philadelphia, was for a time his junior assistant, and Dr. Gouley of New York has recently written me, in an interesting way, of his personal remembrance of Dr. Jameson.

One of the most recent and most interesting of medical publications is entitled "The Medical Annals of Maryland," by Dr. Eugene F. Cordell of Baltimore. I have availed myself of its pages in the preparation of this article.

The profession is indebted to the really monumental scientific studies of Dr. Horatio Gates Jameson of Baltimore, one of the leading surgeons of the period. His experimental studies were in a very large measure duplicated by Lord Lister a generation later. There is abundant evidence that Dr. Jameson was a singularly clean surgeon. His basis studies were made on various animals, and nearly all the wounds were evidently unaffected, since primary union was decidedly the rule. I have been at large pains to follow in detail the history of this extraordinary man as a surgeon, and I judge from his reports that it was the exception that suppuration ensued in his operations.

Few men did so much to give credit to early American surgery as Dr. Jameson, who, from 1820 to 1840, carried the fame of Baltimore as a seat of medical and surgical research to all parts of the civilized world. This truly great surgeon was born in York, Pa., in 1778. His father, David Jameson, also a physician, had a most interesting and adventurous career. A native of Scotland and a graduate as doctor of medicine at the University of Edinburgh, he emigrated to Charleston, S. C., about 1740. He was accompanied by Dr. Hugh Mercer, who settled at Fredericksburg, Va., and became a brigadier-general in the Continental Army, losing his life, as is well known, at the battle of Princeton, in 1777. (One record of General Mercer gives the year of his emigration to America as 1747, two years after the Battle of Culloden, in which he participated as a follower of Bonnie Prince Charlie. This makes it probable that David Jameson was his comrade of battle as well as compagnon de voyage to America, although the family tradition, as remembered by me, does not mention the incident, and yet it is not impossible that both escaped the fate decreed by the curse of Scotland—the famed nine of diamonds).

Dr. David Jameson removed from Charleston, S. C., and settled at York, Pa. He died at Shippensburg, Pa., after the close of the (eighteenth) century. (There is a church record of a daughter born to him in York in the year 1800). He was (an ensign and captain) in the French and Indian War (of 1755, and with the rank of lieutenant-colonel as late as 1769), and in 1755 was badly wounded in an engagement with Indians. (Just a century later his great-grandson was severely wounded in an encounter with the Indians of the Rogue River region of Oregon—in 1755 untrodden by the white man). During the Revolution he was colonel of the Third Battalion of the York County Association (militia). In 1842 the son gave a charming description of his home at York in a Baltimore periodical (the *American Record*, which succeeded the *Baltimore Clipper*); also an account of his father's voyage across the Atlantic, describing among its hardships the short allowance of musty bread and foul water and rusty salt beef doled out, yet consumed by passengers and crew with avidity.

Dr. H. G. Jameson studied medicine under his father, and began practice in 1795, at the early age of 17. (In 1797, at the age of 19, he married, at Somerset, Pa., Catherine Chevelle, a native of Alsace, then a provine of France, and renowned for the beauty of its women, and who died in Baltimore in November, 1837. He settled in Baltimore about 1810, and had two sons born to him there—Dr. David Davis Jameson and Dr. Horatio Gates Jameson of Church Hill, Queen Anne's county, and of Mt. Washington, Md., and five of his grandchildren that survived him). During the War of 1812 he held the office of surgeon to the United States troops at Baltimore, for which his widow (second wife) received a pension after his death. (After he established himself in Baltimore he took the course of medicine in the University of Maryland, and was graduated in 1813. See Dr. Quinan's book.) He was physician to the city jail for several years; from 1814 to 1835 he

was surgeon to the Baltimore Hospital, and from 1821 to 1835 he was consulting physician to the Board of Health.

In 1830, on special invitation, he visited Europe, sailing by the packet running from Baltimore to Germany, and read before the Medical Section of the Society of German Naturalists and Physicians a paper on "The Noncontagiousness of Yellow Fever." He was the only American delegate on this occasion, and the first American to attend these meetings, and felt deeply the honor of his position. His paper was read in translation at the meeting, and was published on his return in his journal. During his brief stay in Europe of two months he traveled through various European countries, staying longest at Copenhagen, to the American representative at which city he bore dispatches from our Government at Washington. (About 1827 he founded the Washington Medical College in Baltimore. Dr. Annan, and, I think, Dr. Dunbar, were two of his contemporaries and associates therein). In 1835, while on his return from Texas, where he had purchased lands, he received and accepted a chair and presidency in the Ohio Medical College at Cincinnati. His colleagues there were Drs. Gross, Drake, Rives and J. B. Rogers—the last his late colleague at Baltimore. (On Dr. Jameson's return journey to Baltimore, by the upsetting of the stagecoach running between Wheeling and Cumberland, his leg was badly broken, and when he reached Baltimore, some time after the accident, he was still on crutches). He removed to (Cincinnati) with his family in October, 1835, and lectured during the ensuing session. (He remained there until some time in March, 1836, when, in consequence of the serious illness of his wife and her earnest desire to return to her old home in Baltimore, he gave up his positions in Cincinnati and returned to the former city and resumed practice there.

Early in 1855 he removed to his native town of York, and during a visit (from there connected with a republication of his work on cholera) to New York he was taken suddenly ill, and died August 24, 1855, aged 76 years. His remains were then taken to Baltimore and interred in the Baltimore Cemetery, corner of Gay street and Boundary avenue.

Dr. Jameson was about 5 feet 10 inches in height, well built, erect and muscular, but not corpulent; his head was covered with a sufficiency of snow-white hair; his face was always clean shaven, his complexion florid and healthy, his face remarkably smooth and free from wrinkles, his eyes dark and piercing and surmounted by bushy eyebrows. He retained his strength and power of endurance to the last. He wore heavy—remarkably heavy—gold spectacles. He dressed in black, wore a black tie and was very careful and neat in his appearance—no one ever saw him look untidy. He spoke German, and was noted for his mechanical ingenuity.

(The interpretations made by me are indicated by parentheses).

Washington, D. C., September 17, 1909.

ITEMS

The surgical staff of the Baltimore Eye, Ear and Throat Hospital gave a dinner Thursday, November 11, 1909, to Dr. Samuel Theobald at the University Club, in recognition of his services as a founder and laborer in the interests of that institution. The occasion was the eve of Dr. Theobald's birthday, and a handsome loving cup bearing an appropriate inscription was presented to him. The presentation address was made by Mr. Charles J. Bonaparte, a member of the board of managers of the hospital. Short addresses expressing appreciation of Dr. Theobald's work were made by Mr. William Bowly Wilson and Drs. Johnston, Hartman, Friedenwald and H. O. Reik.

Dr. Norman Dudley, class of 1901, of Church Hill, Md., was elected a delegate of the Queen Anne's Medical Society to the Medical and Chirurgical Faculty at the annual meeting of the society, held in Centreville, Md., November 12, 1909.

Dr. Albert H. Carroll, class of 1907, of Baltimore, who had contemplated studying abroad, will remain at home during the winter.

Dr. A. C. Smink, class of 1896, who has lived and practiced medicine for the past 10 years at Woodlawn, Md., has moved into his new home at Norwood and Liberty Heights avenue, West Forest Park.

The departments of law, dentistry, pharmacy, medicine and arts (St. John's College, Annapolis) are arranging through a joint committee for a large college dance to be held at Lehmann's

Hall on Thursday, December 16, 1909. This is a move in the right direction, and marks another milestone in the welding of the various and heterogeneous elements of the University into one school instead of a collection of more or less independent departments. The formation of the General Alumni Association in 1903 was the first evidence that the Celestial authorities of the University of Maryland were really waking up; the next sign, the joint commencements of the several schools; the third, Academic Day; the fourth, an apparent arousing of the Board of Regents to the realization that they are concerned with the government of the institution, and fifth, the prospective ball, which is the first joint student affair ever held under the name of the University of Maryland. The BULLETIN congratulates those in charge of the affair, and wishes them much success. The committee on arrangements consists of Messrs. Archey C. New, chairman; S. L. Bachrach and Harry F. Ogden of the law department; Frank P. Fiery, James E. Talbott and George S. Condit, of the medical; Charles D. Ainslie, Walton Graft and Thomas D. Webb, of the dental, and H. E. Wilson, E. R. Hauver and R. P. Hartle, of St. John's College.

Alexander Crever Abbott, class of 1884, was born in Baltimore, February 26, 1860. After graduating he was appointed assistant in bacteriology and hygiene, Johns Hopkins University (1889-1891). From 1891 to 1896 he was first assistant, laboratory of hygiene, University of Pennsylvania. Since 1896 he has been director of laboratory of hygiene and professor of hygiene, University of Pennsylvania. In 1897 he was nominated as director of laboratory of hygiene, Bureau of Health, Philadelphia. He is the author of the "Principles of Bacteriology and Hygiene of Transmissible Diseases." In 1907, during the centennial exercises, he was given the honorary degree of Doctor of Science by his Alma Mater. Dr. Abbott has been a credit to the University of Maryland, and is a well-wisher for its present and future success. He says that the best interests of the University would be subserved by an independent board of trustees, and is of the opinion that we will not attract any large benefactions until the management of the affairs of the institution is entrusted to a disinterested body.

Dr. Harry Cairnes Algire, class of 1895, was born at Hampden, then in Baltimore county, on August 31, 1873. For some time after graduating he was a surgical assistant in the dispensary of the University Hospital. From 1896 to 1898 he held the position of sanitary inspector for the city of Baltimore. Since 1898 he has been a surgeon for the Pennsylvania Railroad. Dr. Algire lives in Hampden, at present a suburb of Baltimore, where he enjoys the confidence of a large clientele.

Dr. Edward Anderson, class of 1875, is a native of Rockville, Md., where he has been engaged in the practice of his profession more than 30 years. Since 1892 he has been a member of the Medical and Chirurgical Faculty. He is also a member of the American Medical Association. Some years ago he was president of the Montgomery County Medical Society. In 1889 he was elected physician of the Montgomery County Almshouse, and has served in that capacity to the present time. He is a frequent contributor to the medical periodicals upon subjects pertaining to medicine and surgery. Dr. Anderson was born May 3, 1841. He is a son of James W. Anderson and Mary Miner Anderson. He is of distinguished Scotch-English ancestry. Dr. James Anderson, his grandfather, was a soldier in the American Army in the Revolution, and one of the founders of the Medical and Chirurgical Faculty. Dr. Edward Anderson received his preliminary education at Rockville Academy. In 1874 he matriculated in the medical department of the University of Maryland, whence he was graduated in 1875 with the degree M.D. After graduating he at once entered general practice in his native town, Rockville, where he has taken a prominent position in his profession. In 1883 he married Mrs. Alice Thompson, widow of Dr. Benet Thompson of Washington, D. C., and daughter of J. J. Lawn of Baltimore, by whom he has one son, Edward Anderson of Washington, an employe of the Interior Department.

Dr. William S. Archer, class of 1880, an A.B. and A.M. of Princeton, is located at Belair, Md.

Dr. Charles D. Baker, class of 1881, is located at Rohrersville, Washington county, Maryland.

Dr. John Barron, class of 1887, of Govanstown, Md., is a native of Ireland, where he was born March 26, 1843. In 1845 he emigrated to the

United States. He receive his literary education at Loyola College, Baltimore, and St. James Institute, Philadelphia, and his medical at the University of Maryland. After practicing in Philadelphia and Baltimore he located permanently at Govanstown, where he still resides.

Dr. Guy Asper, class of 1903, of Chambersburg, Pa., has been confined to the University Hospital with middle-ear trouble.

Dr. Walter Franklin Weber, class of 1909, is confined to the University Hospital with an affection of the kidney.

Dr. William Russell Rogers, class of 1901, of Bristol, Va., paid a flying visit to the University Hospital recently.

Dr. John A. Gibson, class of 1901, of Leesburg, Va., was in town recently, and reports that he is doing well in the practice of his profession.

Dr. William Fulford Sappington, class of 1901, of Websters Mill, Pa., recently paid the University Hospital a visit. He is the same old Sappington as in student days. We are glad to announce that Dr. Sappington has done well in practice.

Dr. Charles W. Famous, class of 1901, of Harford county, Maryland, was a recent visitor to the University Hospital.

Amongst others seen around the corridors of the University Hospital recently was Dr. W. S. Maxwell, class of 1873, of Still Pond, Md.

Dr. Fred Clifton Moor, class of 1903, of Tallahassee, Fla., whilst in town visited his old friends at the University Hospital.

Dr. Charles Edward Terry, class of 1903, Jacksonville, Fla., owing to eye trouble, has been compelled to cease all active work for a time. When in Baltimore recently he said that they were improving, and that he has hopes of being able to engage in internal medicine in the near future. The editors of the BULLETIN desire to here express their sympathy to Dr. Terry, and sincerely wish that in the very near future his sight will be entirely restored. Dr. Terry was an excellent student when in the University, and was universally popular with his classmates. After graduating he settled in Jacksonville, where he had succeeded in building up a profitable practice.

Dr. Jacob Wheeler Bird, class of 1907, of Sandy Spring, Md., is a frequent visitor to the University Hospital.

Dr. C. P. Carrico of Cherry Hill presided at the fall meeting of the Cecil County Medical Society, held at Elkton November 11, 1909.

The following of our alumni are upon the surgical staff of the Hospital for the Women of Maryland: Drs. Chas. Riley, Samuel T. Earle, Robert Wilson, J. Mason Hundley, George W. Dobbin and A. C. Harrison. This institution, which is located at Lafayette avenue and John street, has just completed a new $75,000 addition. The hospital was organized in 1883 by Drs. William T. Howard, Henry P. Wilson and Charles Riley. The two operating-rooms are being erected to the memory of Drs. Wilson and Howard.

Dr. Thomas H. Buckler, class of 1888, has resigned the presidency of the Paint and Powder Club of Baltimore, a position he has held four years.

Dr. Morris Ramsey Bowie, class of 1908, is located at Paonia, Colo.

At the annual meeting of the Nurses' Alumnae Association of the University Hospital, held December 6, 1909, the following were elected to office for the ensuing year:

President—Mrs. Page Edmunds.
First Vice-President—Miss Alice F. Bell.
Second Vice-President—Miss M. E. Elgin.
Secretary—Miss B. C. Weitzel.
Treasurer—Mrs. Nathan Winslow.
First Member—Miss M. E. Rolph.
Second Member—Miss M. E. Lawrence.

Dr. James H. Jarrett, class of 1852, a well-known physician of Towson, who is recovering from an attack of indigestion and vertigo, is able to be in his office again, and expects in the near future to be out. Dr. Jarrett is 78 years old, and has been practicing for 58 years. During the Civil War he served as a surgeon in the Seventh Maryland Regiment, Union Army. Before the war he

was a member of the Maryland Legislature from Harford county. His brother, Dr. Martin L. Jarrett, class of 1864, was elected to the Legislature from Harford county at the recent election. Dr. Jarrett is a member of Wilson Post, Grand Army of the Republic; the Union Veteran Association and the Baltimore County Medical Society.

The engagement of Miss B. C. Weitzel, a graduate of the University Hospital Training School for Nurses, and active member of the Nurses' Alumnæ Association, to Mr. Charles H. McNabb, a rising young lawyer of Belair, Md., has been announced. Mr. McNabb is a graduate of St. John's College, Department of Arts and Sciences.

Dr. FitzRandolph Winslow has taken an office at the corner of Lombard and Monroe streets, Baltimore.

Dr. Randolph Winslow will read a paper on "Acute Abdominal Conditions in Infants" at the coming meeting of the Southern Surgical and Gynecological Association at Hot Springs, Va.

Dr. Martin Bruns, Dr. N. M. Owensby, Dr. Frank Keating and Dr. William F. Swartz attended the last meeting of the Psychiatric Society, held at Bayview Hospital.

Drs. A. Duvall Atkinson, John T. O'Mara and Henry J. Hahn have been appointed visiting physicians to St. Agnes' Hospital; Drs. St. Clair Spruill, J. Mason Hundley and A. M. Shipley, visiting surgeons: R. Tunstall Taylor, visiting orthopedist.

The regular meeting of the University of Maryland Medical Society was held in the amphitheater of the hospital Tuesday, November 16, 1909, at 8.30 P. M. The entire evening was devoted to a discussion of hookworm disease. The program was as follows:

1. Hookworm Disease, Dr. Harry Adler.
2. Discussion, Dr. W. H. Smith and Dr. J. W. Holland.

The General Alumni Association held its fall meeting on Wednesday evening, November 10, 1909, at Davidge Hall. Judge Duncan of Baltimore county made an excellent address upon the duties and obligations of a county judge.

At the meeting of the Section on Neurology any Psychiatry, Baltimore City Medical Society, November 12, 1909, papers were read by Drs. Irving J. Spear, R. P. Bay and R. Martin Bruns.

Dr. and Mrs. Nathan R. Gorter are spending a few days at Atlantic City.

Dr. George I. White, class of 1890, of Marion, N. C., who has been a patient at the University Hospital, has so far improved as to be able to leave for home.

A special service was held in Westminster Presbyterian Church Sunday, November 21, 1909, under the auspices of the Young Men's Christian Association of the University of Maryland. A lay sermon was delivered by Dr. John C. Hemmeter on "Religion and Scholarship, or Divine Knowledge and Human Knowledge." The music was in charge of Miss Lena Steibler of the Peabody Institute, assisted by the Westminster choir. The musical program included solos by Miss Imo Thompson, Miss Elizabeth Leckie, Miss Rose Garrett and Miss Steibler.

The University of Maryland has asked the State Board of Charities to recommend to the Legislature an appropriation of $4000 yearly to this institution.

Dr. John S. Fulton, class of 1881, was elected a member of the executive committee of the American Association for the Study and Prevention of Infant Mortality at its meeting held in New Haven, Conn., November 13, 1909.

MARRIAGES

Dr. William Ellicott Tyson, class of 1905, was married Saturday afternoon, November 27, 1909, in Washington, District of Columbia, to Miss Elizabeth McPherson Weems, daughter of Mr. and Mrs. Juan Crampton Weems. Dr. Tyson was for a time resident physician in the maternity department of the University of Maryland; later a resident physician in the Women's Hospital, Kensington, Philadelphia, Pa., and now a resident of Detroit, Mich. The nuptial knot was tied by Rev. Thomas Alexander Johnstone, rector of St. Phillip's Church, Laurel, Md. The ceremony took

place at the home of the bride's parents, 1727 19th street, Washington, District of Columbia. The bride was attended by her sister, Mrs. Waterman Allen Taft, of Boston, as matron of honor, and another sister, Miss Frances Weems, was bridesmaid. Dr. Riddon Dees of Greensboro, N. C., was best man. After the ceremony Dr. and Mrs. Tyson left for a trip North, and will be at home in Detroit on the first of the new year. The bride is a granddaughter of the late John D. McPherson of Ever May, Georgetown. Her father is a grandson of the late John C. Weems of Loch Eden, West River, Maryland. The bridegroom is a member of the Tyson and Ellicott families of Maryland.

Dr. Robert Levis Mitchell, class of 1905, an ex-resident gynecologist to the University Hospital, and at present an assistant in the gynecological department of the dispensary of the University Hospital, an ex-houseman, and in his student days a member of the football team, also a graduate of the department of pharmacy, was married Wednesday, November 17, 1909, in the Presbyterian Church at Elkton, Md., to Miss Annie Inskip Smith, daughter of Mr. and Mrs. William Bass Smith, of Elkton. After their honeymoon Dr. and Mrs. Mitchell will make their home in Baltimore.

Dr. John Robert Paddison, class of 1902, of Oak Ridge, N. C., and Miss Zora Sapp of Kernersville, N. C., were married at St. Leo's Hospital in Greensboro, N. C., October 28, 1909. The ceremony was performed immediately preceding an operation for appendicitis which Dr. Paddison underwent successfully.

Dr. Edwin Ferebee Fenner, a young physician of Henderson, N. C., and Miss Louise Sampson of Manchester, Va., were married in the Presbyterian Church of that city on the evening of October 20, 1909. Dr. Fenner is a graduate of the University of Maryland, having graduated from this institution in the spring of 1905. He is a popular physician of Henderson, and has many friends there as well as throughout the State.

Dr. Peter McLean, a prominent young physician of Laurinburg, N. C., and Miss Alice Lee Elliott were married at the bride's home on Little River, North Carolina, on October 30, 1909. Dr. McLean graduated from the medical department of the University of Maryland in 1906, since which time he has been a very successful practitioner. He received his license to practice medicine in 1907 and joined the North Carolina Medical Society in 1908.

Dr. Preston G. Hundley, class of 1909, of West Virginia, was married Wednesday, November 24, 1909, to Miss Mary E. Lyell, only daughter of Mr. John M. Lyell of Richmond, Va., at Brantly Baptist Church, Baltimore, by the pastor, Rev. Dr. H. M. Wharton, assisted by Rev. John T. Hundley of Norfolk, Va., a brother of the groom. Immediately after the ceremony Dr. and Mrs. Hundley left for a wedding journey South, and will live in West Virginia.

Mr. William Ebert, class of 1912, and Miss Louise Bowly of Baltimore were married September 29 at Wilmington, Del.

DEATHS

James Wells Herbert, class of 1871, for several years apothecary at the Marine Barracks, Washington, District of Columbia, and prior to that time surgeon to the United States Steamship Lancaster, died at his home in Washington September 5 of paresis, aged 59.

Dr. Levin Gillis Owings, class of 1900, of Ellicott City, Md., a young and promising physician of Howard county, died at the home of his father, L. I. T. Owens, at Ruxbury Mills, of tuberculosis. Dr. Owins had been in failing health for two years. At the onset of his sickness he went to the Adirondacks in search of health, but was not benefited, so returned home, where he remained until the day of his death. Dr. Owings was a son of ex-County Commissioner Owings, and was a graduate of Western Maryland College, and the medical department of the University of Maryland. After graduating Dr. Owings was an interne in the University Hospital on the medical side for a year. He then went to Ellicott City, where he opened an office. He was engaged in active practice until two years ago, when his health became such as to force him to forego further work. Besides his father, he is survived by two sisters, Misses Ruth and Minnie Owings, and one brother, Mr. Thomas Owings, of Montgomery county, Maryland.

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RELIGION AND SCHOLARSHIP; OR, DIVINE KNOWLEDGE AND HUMAN KNOWLEDGE.

A Lay Sermon by John C. Hemmeter, M.D., Ph.D., LL.D.,
Professor of Physiology and Clinical Professor of Medicine in the University of Maryland.

Delivered by invitation of the Young Men's Christian Association of the University at Westminster Presbyterian Church, Baltimore, Sunday, November 21, 1909.

INTRODUCTION.

When a man of learning becomes a disbeliever there is exultation among the skeptics and atheists. "Behold the fruits of the highest intellectual culture!" they cry. "Behold, the result is the turning away of man from God!" And then follows the enumeration of all men of great intellect who have been agnostics or atheists. Notably around Charles Darwin does the polemic of disbelievers wage most fiercely, for in the "Life and Letters of Charles Darwin" by his son, Francis D., we gain an insight into the process of getting lost in disbelief of the eminent naturalist. On p. 278 of Vol. I of this work we learn that there were chiefly two reasons for this skepticism—(1) the incredibility of the miracles by which he assumes Christianity is supported, and (2) that the old argument from design in nature as given by Paley which "formerly seemed to him conclusive" failed now that the *"law of natural selection"* had been discovered. Opposed to the first of these reasons are the words of the founder of Christianity Himself, that He did not intend that His religion should be founded on miracles (John iv, 48; Matthew xii, 38 and 39). It is, therefore, a fundamental error when this great thinker assumes (in his "Autobiography," written in 1876) that Christianity needs the support of miracles. Darwin, as the father of the law of natural selection, was led to think more and more objectively, and confesses that as he lost interest in music and poetry, so he forgot how to think spiritually. The father of a new direction of human thinking naturally becomes disinclined to agree with any doctrine that is seemingly at variance with the new law he has discovered. This feeling of antagonism to anything that tended to oppose his mental offering was to be expected. *It will always be strange that it should be thought the safest course to separate as sharply and as widely as we can between that which we are called upon to believe in religion and that which we are able to trace or understand in nature.*

One of the profoundest arguments in the entire range of Christian philosophy is presented by Butler in his "Christian Analogy" concerning this apparent antithesis between religious faith and faith in science. All the steps of the argument of Butler are founded on the opposite belief, namely, that all the truths, and not less all the difficulties, of religion *have their type and likeness in the constitution and course of nature.* This reasoning is as profound as it is simple, and as we follow it our eyes are ever and anon opened to some new interpretation of familiar facts, and we gradually learn to recognize among the curious things of the earth one after another of the laws which, when told us of the spiritual world, seem so perplexing and so hard to understand.

Concerning the argument that the discovery of the law of natural selection had invalidated the belief in purpose and design, in the results and methods of creation, this has been completely answered by the Duke of Argyle in his "Reign of Law" (see this book and Note A to p. 46); also his discussion with Mr. Wallace in the *Journal of Science,* No. 16, October, 1867. After reading these able discourses I believe every evenly balanced mind will feel satisfied that between the scientific conception of the law of natural selection and the religious conception of purpose or design in creation there is no conflict.

Mr. Wallace virtually admits that it dwindles down to this: "It is simply a question of how the Creator has worked." But if we desired any further harmonizing of these apparent discrepancies between fundamental scientific and fundamental religious opinions we find them in Henry Drummond's work on "Natural Law in the Spiritual World."

In this connection I feel it my duty to call attention to the modern tendency of some of the most prominent representatives of natural science to become dogmatic. Dogmatism, which by Haeckel, Huxley and others was asserted to be the exclusive possession of religious people, is frequently observed in scientific arguments, whilst it is claimed with equal firmness that open-minded intellectual integrity and courage are the characteristics of those that reject Christianity. According to Lyman Abbott, a man of great intellectual distinction who counted himself an agnostic said not long ago of an equally distinguished man who was an ardent Christian: "I don't see how it is possible for so able a man to believe the fairy tale of Christianity. He cannot be entirely sincere." This assumption that a person of superior intelligence must be a skeptic overshadows the faith of many good people. The remark quoted is very similar to those I have personally heard during conventions of scientific men in this country and abroad, where it occasionally becomes evident that among those who lay great claim to liberalism there are a surprising number who are conspicuous for narrowness and dogmatism.

The assumption of the intellectual superiority of the skeptic over the adherent to faith is born of pure arrogance. It has no authority to challenge belief as if it were the sole custodian of truth. In the following sermon on the interview of Christ with Nicodemus I shall endeavor to make clear the particular susceptibility of learned men to lean too much toward objective evidence and to lose the spiritual side of their natures, and even to suggest that faith rests solidly on the largest and most courageous use of reason, by which I mean the full play of all the human faculties, the complete exercise of human knowledge.

In one of the most masterly and scholarly contributions to this subject Josiah Royce says (*Harvard Theologic Review,* October 1909, p. 434, "What Is Vital in Christianity?"): "The world of our usual human experience is but a beggarly fragment of the truth, and if we take too seriously the bits of wisdom that it enables us to collect by observation of special facts and of natural laws it becomes a sort of curtain to hide from us the genuine realm of spiritual realities in the midst of which we all the while live."

The effort to found a new religion on the basis of *natural law* as revealed and understood by human intellect has been made many times and long before the scholarly attempt by Dr. Charles Eliot, the erudite ex-president of Harvard University (*Harvard Theologic Review,* October, 1909, p. 389). But laws (see Duke of Argyle on the "Reign of Law") do not explain anything except the order of subordinate phenomena in nature. They set forth that order as due to force; they do nothing more. They do not explain the force of which they are the resultant.

Least of all do laws explain themselves. They suggest a thousand questions much more curious than the questions they solve, or, rather, attempt to solve. The very beauty and simplicity of some laws is their deepest mystery. What can their source be? How is their uniformity maintained? All that we ever know is some numerical rule or measure according to which some *unknown forces* operate. But whence come those measures we are not told. They are the result of human speculations, of the operation of our senses. But, unlike the ordinary consciousness, the religious consciousness is concerned with that which lies beyond the sphere of sense.

The unreliability of a religion that is based on what human beings recognize as "natural law" is evidenced by the errors our sense faculties have been shown to exhibit. The views of today—say of the constitution of matter and the laws of Keppler and Newton that hold matter together—may appear satisfactory to us for the present, but how will these laws be regarded by the physicist at the end of the twentieth century? According to Faraday and Sir William Crookes, we are incessantly learning the lesson that our researches have only a provisional value.

The view of Crookes ("President's Address to British Chemical Society," March, 1880) that all of our chemical elements have been formed from one primordial substance is gaining ground among physicists, and with it the view that all matter now existing is disintegrating at almost immeasurably slow rate and reverting to the state of this single primordial element, which he terms

protyle. The rate of this disintegration is expressed by Becquerel in his calculation, in which he believes to have shown that one square centimeter of radioactive surface would radiate into space one gram of matter in one billion years, or, according to Crookes, if one million atoms fly off every second it would require a century to diminish one milligram. This fatal quality of atomic dissociation appears to be universal, not only in radium, where it is most active, but in all matter. It operates whenever a piece of glass is rubbed with silk in the ordinary friction machine, it works in the sunshine and rain drops, and in the lightning and flame, it prevails in the waterfall and stormy sea, and although the whole range of human experience is all too short to afford a parallax whereby the date of the extinction of matter can be calculated, protyle—the formless mist, the primordial mother substance of all matter—once again may reign supreme, and the hour hand of eternity will have completed one revolution.

"If thou wouldst know the mystic song
Chaunted when the sphere was young,
Aloft, abroad, the pean swells—
O wise man, hearest thou half it tells?
To the open ear it sings
The early genesis of things;
Of tendency through endless ages
Of star dust and star pilgrimages,
Of rounded worlds, or space and time,
Of the old flood's subsiding slime,
Of chemic matter, force and form,
Of poles and powers, cold, wet and warm;
The rushing metamorphosis
Dissolving all that fixture is,
Melts things that be to things that seem,
And solid nature to a dream."

—*Emerson.*

These are examples of the imaginings of some of the foremost physicists, and upon such speculations it is suggested a religion could be founded —as possibly it could. But if natural laws as we formulate them are based either on speculation or research, and if both of these have only a provisional value, the question is justifiable, What enduring power can a religion have that is built upon such human endeavors? Harnack ("What Is Christianity?") states a truth of enormous penetration when he declares that it was one of the enduring qualities of religion of Christ that no effort was made to found it upon science—in the first place, because the domains of religion and science are entirely different, and, secondly, because a religion that would have to change its foundation as often as science has already done could not inspire the confidence of a Divine revelation.

In elaborating on the following quotation from the third chapter of John, I lay no claim to originality in the manner in which the subject is treated. I can only say that having heard it treated in that way by Consistorialrath E. Ohly of Wiesbaden and Dr. Frederick Lynch of New York, I am quoting largely as I remember their sermons:

"There was a man of the Pharisees, named Nicodemus, a ruler of the Jews. The same came to Jesus by night, and said unto Him: 'Rabbi, we know that Thou art a teacher come from God: for no man can do these miracles that Thou doest except God be with him.' Jesus answered and said unto him: 'Verily, verily, I say unto thee, except a man be born again he cannot see the kingdom of God.' Nicodemus saith unto Him: 'How can a man be born when he is old? Can he enter the second time into his mother's womb and be born?' Jesus answered: 'Verily, verily, I say unto thee, except a man be born of water and of the spirit he cannot enter into the kingdom of God. That which is born of the flesh is flesh, and that which is born of the spirit is spirit. Marvel not that I said unto thee, ye must be born again. The wind bloweth where it listeth, and thou hearest the sound thereof, but canst not tell whence it cometh and whither it goeth; so is everyone that is born of the spirit.' Nicodemus answered and said unto Him: 'How can these things be?' Jesus answered and said unto him: 'Art thou a master of Israel and knowest not these things? Verily, verily, I say unto thee, we speak that we do know, and testify that we have seen; and ye perceive not our witness. If I have told you earthly things, and ye believe not, how shall ye believe if I tell you of heavenly things?"—*John* iii, 1-12.

FIRST EARTHLY THINGS, THEN HEAVENLY.

It is much to be regretted that more of the conversation of Jesus with scholars of His day and with strangers have not been recorded, for in these familiar talks He said some of His greatest and most far-reaching things. Here in this formal conversation with Nicodemus He uttered

the foundation truth of religion, namely, the Divine spirit of God reaching down and lifting men up into the kingdom of heaven. That is the beginning and end of religion. This conversation is especially interesting because it is with a scholar, and Jesus had very little contact with the educated men of Israel. Nicodemus was a learned lawyer and was very much interested in religious questions, particularly their intellectual and political aspects. He had, doubtless, as the chief desire of his life, the restoration of the kingdom of Israel. Stirred by his prophetic books, he was eagerly watching for signs of its approach. John the Baptist's preaching, that it was near, may have awakened in him renewed expectancy. Anyhow, he eagerly follows Jesus and becomes intensely excited over His deeds and words. As soon as night comes, when he can find Jesus alone, he seeks Him, and then ensues one of the most interesting conversations ever held. Of course, we have only a fragment of their talk. Perhaps they talked long into the night. But we have enough of outline to reconstruct it.

Nicodemus says to Jesus that he has heard Him preach, and, although much interested, could not understand His teaching; but he was very much impressed by His miracles, and knows that He must have come from God and that God is with Him, otherwise He could not do those wonderful things. Then Nicodemus must have told Jesus that He was just the man to take hold of the Jewish people and gather Israel about Him and establish the kingdom, set the church on its old foundations and bring back the departed glory of Zion.

Then Jesus must have spent a long time in disabusing Nicodemus' mind of this false idea of the kingdom, showing him its real nature—how it was an inward kingdom, independent of States or churches, strength or weakness, riches or poverty; how it was a state of being, a disposition, a communion with God, the eternal life.

Nicodemus listens absorbedly, but at last exclaims: "It is beautiful, wonderful, but I cannot understand, I cannot see it."

Then Jesus utters the one great secret of all spiritual living—"Except a man be born anew, born from above, he cannot see the kingdom of God."

But all this was utterly outside Nicodemus' experience, and he vaguely shakes his head and says: "How can an old man be born again?"

Then Jesus repeats and explains: "Except man be touched and awakened from above by the Spirit of God he cannot find the way into the kingdom. That which is born of flesh is flesh, and can comprehend only fleshy things; that which is born of the Spirit is spirit, and can comprehend the things of the spirit. Just as the wind roams over the earth, doing its mysterious work, and man can only wonder and have no power over it, so the Spirit of God touches the hearts of men in the same mysterious way and works its holy wonders in them."

But Nicodemus had neglected his spiritual nature, and this is all foreign language to him. And Jesus is surprised and somewhat impatient, and exclaims: "Art thou a teacher of religion in Israel and know not the simple beginnings of religion? If you have not believed and lived the simple earthly principles of cultivating the spiritual life and common virtues which you have heard Me teach, how can you understand and believe if I tell you heavenly things?" Then Jesus goes on to explain His own relation to the kingdom. And late in the night Nicodemus goes home to ponder these things, and he ponders them to his redemption, as we shall see.

This is about the way in which Consistorialrath Ohly and Frederick Lynch interpreted this fascinating discourse. Now as to our deductions.

"Unlike the ordinary consciousness, the religious consciousness is concerned with that which lies beyond the sphere of sense. A brute thinks only of things which can be touched, seen, heard, tasted, etc., and the like is true of the untaught child, the deaf-mute and the lowest savage. But the developing man has thoughts about existences which he regards as usually intangible, inaudible, invisible, and yet which he regards as operative upon him."

So says Herbert Spencer. If this be true, then he who is more than a brute, who thinks sometimes of what cannot be touched, seen, heard, tasted, etc., will be interested to know what one of the greatest religious teachers of the ages has to say about the one great Being who is intangible, inaudible, invisible, and yet is operative in mankind. What does Jesus teach about God? And this question will interest the thoughtful man, whether or not he thinks that Jesus possessed a Divine or even an exceptionally prophetic character.

Herbert Spencer has said that nothing is more certain than that we are ever in the presence of an Infinite and Eternal Energy, from which all things proceed. At least twenty-odd centuries before Herbert Spencer an unknown Hebrew poet had said the same thing:

"Whither shall I go from Thy Spirit?
Or whither shall I flee from Thy presence?
If I ascend up into heaven, Thou art there;
If I make my bed in hell, behold, Thou art there;
If I take the wings of the morning
And dwell in the uttermost parts of the sea,
Even there shall Thy hand lead me,
And Thy right hand shall hold me."

What did Jesus teach concerning this intangible, inaudible, invisible, yet universal Presence?

First of all, that the "knowledge of God is not school knowledge; it is life knowledge; not information, but acquaintance." "God is not to be known by reasoning out doctrines of Him, but by living with Him." "A man is to know God as a child knows his parents—by experience." So, for the answer to the question, What did Jesus teach? we are not sent merely to the Four Gospels. We are sent to the experience of the pupils of Jesus. What is the conception of God which has grown up in the experience of Christians out of the teaching of Christ? Or, to turn back to the phraseology of Herbert Spencer, if the developing man has thoughts concerning the invisible but universal presence, what are the thoughts of those who consciously owe their religious development to the teachings of Jesus Christ?

Christians universally believe in a personal God. What do we mean by a person? Why am I, I; and you, you? We mean consciousness and choice; some knowledge of ourselves, and some power to direct ourselves, or, in more technical language, self-consciousness and self-determination. In the experiences of all Christians, and in the teaching of Jesus that has come down to us, this is the first and most fundamental truth. This inaudible, invisible, universal Presence, this Infinite and Eternal Energy from which all things proceed, is one who is related to men, one between whom and men communion, fellowship, converse is possible. This Presence is "*He*," not "*It*." Says Matthew Arnold: "Many excellent people are crying out every day that all is lost in religion unless we can affirm that God is a person who thinks and loves." These many excellent people are right in so far as this: it is true that what is most fundamental in the Christian religion is lost unless we can affirm that God is a person who thinks and loves. For the whole of the Christian religion might be said to be summed up in the words, "Say, Our Father." For it all grows out of the faith that Christian experience is common to humanity—that is, religion is a common, and may be a universal, experience, and that it is an experience of conscious filial relation to the Infinite, who is never perfectly understood, but need never be unknown. Christianity does not approach God as a Great First Cause—that is, through philosophy; it approaches Him as the Great Companion—that is, through experience.

One more illustration must suffice here to complete this hint as to a doctrine of God built out of human experience. What do we mean by the transcendence and what by the immanence of God? What is there in personal experience which answers to these phraseologies? Two truths of universal consciousness: I am more than the body which I inhabit, and it is subject to me—a truth which psychology may interpret or explain, but can never successfully controvert. But I am also equally present in all parts of my body, and in a state of health it is all alike a part of my domain. Use this human experience to interpret God's relation to the universe. First, God is Spirit and transcends the universe. "He, and He alone, exists in and of Himself, * * * while the universe, His sole companion in existence, exists simply and solely because of Him. He is the Creator; it is the creature. His is the will, and the universe is the response. In self-existence and creatorhood He stands transcendent." And, second, this transcendent Spirit is no absentee God, detached from the universe, a localized Deity dwelling in the sky, as still many hymns and prayers represent Him to be. "All opportunity to think of an infinitely distant home of God is crowded out, and it is by a practical necessity that we look upon Him as a pervading Presence. If we are to think of Him as anywhere, we are compelled to think of Him as everywhere." In this respect, as we have already pointed out, the scientific conception, as interpreted by Herbert Spencer, and the spiritual conception, as interpreted by the ancient Psalmist, are essentially one. The testimony of religious experience modern science confirms. (Lyman Abbott.)

There are two great truths of universal import in this conversation. The first is this: The way to enter the kingdom of God is not so much by effort, not by acquiring great knowledge, as by response to the Spirit of God. There are two kingdoms—a kingdom of the flesh and a kingdom of the spirit; a kingdom of the animal and a kingdom of the soul. Every man is born with power to respond to the impact of these two kingdoms. Food, air, water, all kinds of natural powers, beat in upon him from the world and develop his body if he will let them. Likewise, says Jesus, Divine forces beat in as winds upon man's soul to quicken his soul-life if he will let them. Man is meant to keep both sides of his nature open to these double influences from birth and let his life be developed in proper harmony. It was not many years ago when men said that during the first 15 or 20 years of a man's life, during childhood and youth, let him be responsive to the fleshy influences only; then suddenly bring the spiritual influences upon him with tremendous force, and let them pry open his heart and take it so as by force. This was the false idea that Bushnell fought so hard. It was contrary to nature. His contemporaries accused him of not believing the truth that a man is born into the kingdom from above. Bushnell answered, in substance, that he believed it with his whole heart even more than they did.

"Only," he said, "it ought to be contemporaneous with physical development. You immediately put the child under fleshy influences, and he is gradually adjusted to the natural kingdom; so, also, put him under spiritual influences and let them lift him up into the kingdom of God."

And Bushnell was right. Today we are trying to rear children so that they shall be simultaneously fed from both kingdoms. In the normal life these two processes develop side by side—the body fed from earth, the soul nourished from heaven.

But how many men respond only to the impacts of earth and belong only to the earthly kingdom? How many men pass into old age hardly feeling one quickening, regenerating touch of those breezes that sweep the earth from the spirit world? They are not always nor necessarily bad men, but they have nothing higher born within them than earthly forces can generate. They have felt the impact of the earth and air, of work and comradeship, and have sometimes risen high from earthly impellings. Nicodemus was just this type of man. He had been born, as is every man, with power to respond to the two kingdoms —the seen and the unseen, the human and the Divine. Jesus saw at a glance that he had lived entirely in the seen world and been shaped by its forces only. His idea of the kingdom was material. He was interested in miracles and theology—all the concrete, earthly sides of religion. His ideals never rose beyond prudence; his aspirations never soared above the earth or beat against the sky; his nature had not throbbed and bounded to anything intenser than the thrills of earth. Now, to Nicodemus, and to us all, Jesus says that just as a man is adjusted to the natural world and born into the power of the fleshy kingdom, not alone by efforts of his own, but by submitting himself to the impact of the world forces, so a man is born into the kingdom of God by humbly opening his heart to the incoming of the Divine Spirit and letting it shape him into harmony with the things of heaven.

There is a Divine, heavenly, spirit force in this world. It is just as real as earthly forces. It is more real, for it rules them and is above them. It is the Spirit of God Himself. It is God—operative, energizing, redeeming men. It is the soul of the universe, everywhere present. It is here, beating against the human heart, as the ground beats against the feet or the winds against one's cheek. To get into this kingdom one who has lived only in the fleshy kingdom must open wide the windows of his heart, make the heart clean, pure and inviting, pray, live a life conducive to the Spirit's entrance, cherish the Spirit when it comes, make the chief end of life to keep responsive to its touches, and thus let himself be born, regenerated, quickened from above. With the Spirit's entrance new, heavenly powers will pulsate through our frames. Our souls will swell with refreshing currents. New visions will flash upon us far surpassing earthly landscapes. New truths will fall into the mind far beyond man's finding. Ideals will spring up that burn like stars. Purposes will grow to find their consummation in other worlds. For, with the Spirit comes the consciousness of immortality. The kingdom of God is an eternal kingdom. To be born of it is to become one with its eternity. Peace will come, for peace is the gift of God. Life will bring forth new virtues, new beauties, new heroisms, new powers to love and suffer. We will live by new laws and diviner mo-

tives, lean on new arms, live with new friends, have our life in God. "Like an exotic plant in a temperate zone, the soul without God bears only leaves." With God it bears heavenly fruits and takes His likeness upon itself.

This, then, is the way into the kingdom. Unaided, man may go far, but for entrance into the full-orbed glory we must be born into it by the touch of the Divine Spirit from above.

To be born from above—how we all need it!—need to be made over even every day, need psychic cleansing, regenerating, lifting into higher life! How we need to be born again in our purposes! How we need to have our loves exalted and purified, our emotions deepened and sanctified, our interests expanded, our hearts cleansed, our sins washed away by the Spirit's cleansing presence! How we need enlargement of life, our lives transformed and transfigured by the glory of God's abiding presence! How can we be long content to live in the small kingdom of the earth when the other kingdom, with its glories, lies just above and around us and stoops down to lift us up when we yield? We belong to the kingdom of God by nature. We have strayed from it, kept ourselves from its blessed fields. But it is ours if we will. Said Jesus, "Come ye blessed of My Father, inherit the kingdom prepared for you from the foundation of the world."

Let us now look at the other and closely allied truth which Jesus emphasized in this conversation. It has to do with the comprehension of religious truth. He gives here a helpful and universally true motto, a natural and unfailing way of approach to truth: "First earthly things, then heavenly." Nicodemus had been seriously trying to comprehend the new doctrines Jesus taught. He was a good man and really wanted to understand these doctrines, but they were too transcendent for him. We today cannot realize how transcendent Jesus' teachings were to an Israelite. Jesus sees Nicodemus' trouble, and says: "Nicodemus, you cannot understand these heavenly things until you have fulfilled their earthly requirements." That is, according to Jesus, it is not by cold, abstract processes of reasoning that Nicodemus could get insight into the higher spiritual laws, but by a process of living. He could not understand heavenly things until he was filled with an enthusiasm for Godlike life here on earth.

It is a great truth. Earthly virtues are the paths over into heavenly truths. The virtues come first. We walk over into the meaning of the doctrines of the kingdom by obeying its laws. "He that doeth the will of God shall learn of the doctrines." If we want to understand the lofty things Jesus taught, we must walk with Him in lowly ways of love and duty. Forget your mental troubles and live in His Spirit, and the truths He taught will grow luminous. Sometimes the way to seek spiritual truth is not to make any special efforts to seek it, but by holy living prepare yourself to let it break in upon you of its own will. It will come when the heart is ready. None of the disciples understood Jesus' teaching during the first few months they followed Him. Instead of explaining His doctrines, He said: "You will hear when you have ears to hear," and set them to living His commandments. After a while the deep meaning and mystery of the truth came—silently, unsought, as the dawn comes. Children first learn to speak the language; by and by, with the years, the meaning comes. If we live the Sermon on the Mount, by and by we can understand the last chapters of John—first the natural, then the spiritual; first doing, then knowing; first life, then its meaning; first earth, then heaven.

Or we can put this same truth another way—spiritual vision depends on spiritual manhood. Moral enthusiasms must precede heavenly mysteries. There is a beautiful verse in the Revelation which, in speaking of the heavenly music the poet heard in his vision, says, "But no man could learn that song excepting them which had been redeemed from the earth," which is only another way of saying that only the pure in heart can hear heavenly voices or see God. If we wish to see heavenly things, we must cultivate the eye of the soul—make it single, pure. Spiritual truths are revealed to the spiritual man. God is spirit, and they who would know Him must know Him in spirit and in truth.

Who knows but that if we today would make our hearts as pure as were the hearts of prophets and disciples of old we might have such visions again of God in His world? I myself have an unfaltering conviction that if God's voice is not heard today as distinctly and gloriously as it was heard by the writers of the Bible, it is not because God is not trying to say just as great and as important things to us, but because we are not religiously sensitive enough to hear. I see no reason why Bibles should not be written today if men would only make themselves as spiritually sensi-

tive to God's presence as men were in the older days. God is not absent, neither does He speak to one time and neglect another. If we see Him not today, it is not because He is not here, but because our vision is clouded. May it not be that when we have passed through this period of materialism in which now we rush and strive, and turn again to the things of the soul and reach out for the higher life, new prophets shall arise and new books of God be written, and new psalms be sung, and there be open vision again of God's presence here on earth?

Or, to put it in still another way, one must enter into the spirit of a thing before he can understand it. The reason Nicodemus could not comprehend what Jesus said about the kingdom was because he was not in sympathy with it spiritually. So Jesus says to him: "It is vain for Me to try and explain the Divine mysteries of My kingdom, Nicodemus, while you have no sympathy with the kingdom itself." This is the heart of the matter. We cannot comprehend the beauties of Divine things until we enter into oneness with their purpose. We see the meaning of things according to the spirit that animates our searching. The artist looks at the landscape and sees a thousand beauties hid to common eyes. To enjoy music to its fullest extent we have to know its laws and make for ourselves poetic natures. In all things we have to bring ourselves up to the level of that which we should comprehend. The universe is full of the revealings of God. No man would dare hint at the thousands of even natural forces as yet unfelt and unseen—unfelt because we have not yet developed ourselves enough to feel. When we develop our mental sensitiveness up to a certain point a new world of stars bursts in upon it or a Roentgen ray. One of the zests of living is the consciousness that as we grow in mental receptiveness new and wonderful things out of the unseen world will flood our minds. So, too, as we learn to love spiritual things and become possessed with a great enthusiasm for the kingdom of God, and go out into life looking and longing for God, and make our souls sensitive to Divine and holy things, there shall grow up within us an abiding sense of the nearness of the blessed Spirit presence, and secret mysteries of heaven shall begin to unroll their meaning before our eyes, and streams of power and plenty begin to roll in upon us out of unseen worlds, and all the earth begin to glow with the glorious presence of the Lord. First the trained and sympathetic heart, then the kingdom; "first earthly things, then heavenly."

We are fortunate enough to know that Nicodemus followed these rules we have been studying and that they brought him into the kingdom. For, two years later, when the Jews would sentence Jesus without trial, we find Nicodemus pleading His cause, and, at the last, we find him, in his great devotion, doing honor to the dead body of the Lord; for, says John:

"There came also Nicodemus (which at the first came to Jesus by night), and brought a mixture of myrrh and aloes, about a hundred-pound weight. Then took they the body of Jesus and wound it in linen clothes with the spices, as the manner of the Jews is when they bury."

This was the truest indication that Nicodemus then understood the teachings of Christ, because his was a great sacrifice to give up his lordly station in the Jewish hierarchy of that day and become a disciple of the Lord.

"Wherever through the ages rise
The altars of self-sacrifice,
Where love its arms has opened wide
Or man for man has calmly died,
I see the same white wings outspread
That hovered o'er the Master's head."

ETIOLOGY OF NEPHRITIS.

By John E. O'Neill,
Senior Medical Student, 1910.

In the discussion of a disease such as this, where oftentimes one particular form merges into the other, and where we frequently find as a consequence of this that the varieties of classifications are, to say the least, confusing, it will probably be better for our present purpose, from the standpoint of the etiology, to present merely a consideration of the three main clinical forms, namely, acute diffuse nephritis, chronic parenchymatous nephritis and chronic interstitial nephritis.

Acute diffuse nephritis (known generally as "acute Bright's") is due, in practically all cases, to one of six causes, or possibly several of these acting together. They are: (1) cold and exposure, (2) poisons of the specific fevers, (3) toxic agents of a chemical nature, (4) pregnancy, (5) skin lesions and (6) trauma.

As to age, it more often appears *before* than

after middle life; and as for sex, males are more susceptible than females, particularly when engaged in occupations requiring exposure to cold and wet.

Taking up these causes separately, the first (cold and exposure) is probably the most frequent. In the opinion of most authorities, cold of itself rarely produces marked renal disturbance, some predisposing cause being necessary, and such a predisposing cause, in the great majority of cases, is alcoholism—either the habitual use of alcohol or the state of lowered resistance following a drinking bout. Quite a difference of opinion exists as to alcohol being solely responsible, one authority stating that "alcohol probably never excites an acute nephritis," whilst another asserts positively that "acute intoxication from beer drinking itself *may* cause an attack of acute nephritis." In the rare cases, where cold seems to be the only factor concerned, it may possibly be due to congestion (the blood having been withdrawn from the peripheral circulation) or to the action of toxic substances retained in the circulation as a result of the lessened activity of the sweat glands.

The next cause of acute nephritis—and a frequent one—is poisons of the specific fevers. By far the most common of these is scarlet fever, in which disease it may supervene during the height of the fever, or, rather, when the disease is at its worst, but more often it occurs in the second or third week of convalescence. Less commonly acute nephritis occurs in, or as a sequelæ of, typhoid, measles, diphtheria, smallpox, chicken-pox, malaria, cholera, yellow fever, meningitis, and very rarely dysentery. It may be associated with syphilis and with acute tubercular lesions, particularly the former. Bradford states that probably many of the idiopathic cases, and even those ascribed to cold, may be of syphilitic origin. It may also occur in septicemia and in acute tonsillitis, and is not uncommon in exudative erythema and the allied purpuric affections.

The third cause mentioned above was toxic agents of a chemical nature. Here we meet with such substances as turpentine, cantharides, potassium chlorate and carbolic acid—substances which may bring about an acute congestion which sometimes terminates in nephritis. The excessive ingestion of highly acid, spiced or adulterated foods is certainly deserving of some consideration in this connection, some individuals being more susceptible than others. Ether anesthesia may occasionally cause renal inflammation.

The next condition mentioned as being causative of acute nephritis is pregnancy. The etiology of the nephritis of pregnancy is still undetermined, but is probably due to one of two factors—(*a*) compression of the renal veins or (*b*) the action of toxic products. That the former is the more probable of the two is evidenced by the fact that it occurs more often in primiparæ than in multiparæ, and is there found in the last months of pregnancy.

An occasional cause of acute nephritis comes fifth on the list, being skin lesions. In these may be included burns, the nephritis being due to the taking up by the circulation of toxic or toxic-like substances from the detritus at the site of the burn. In certain chronic skin diseases acute nephritis is not infrequently an accompaniment.

Sixth and last is trauma, using the term in a rather broad sense. Under this also may be included the extension of inflammatory products from below and from contiguous structures, as in psoas abscess.

Coming now to the first of the two chronic forms, chronic parenchymatous nephritis, we find that it is due mainly to one of three causes: (1) following acute nephritis, (2) alcohol, (3) as a complication. As in acute nephritis, chronic parenchymatous is found more frequently in males than in females, and is met with most commonly in young adults.

First, "following acute nephritis"—more frequently than is usually stated the disease has an insidious onset and occurs *independently* of any acute attack, but in most of these cases we find the fevers playing an important rôle. In this connection I. E. Atkinson and Thayer lay special stress upon malaria as a cause. It not infrequently follows the acute nephritis of cold.

The second causative factor mentioned was alcohol. There seems to be no doubt that alcohol may cause this form of the disease, although opinion seems to be somewhat reserved on the subject.

Lastly, as a complication. In chronic suppurative syphilis and tuberculosis parenchymatous nephritis is not uncommon, and is usually associated with amyloid disease.

Probably the most interesting form of nephritis is the one about to be considered—chronic inter-

stitial. The course leading to it may be grouped as follows: "(1) heredity, (2) syphilis, (3) overeating, (4) alcohol, (5) secondary to arteriosclerosis and (6) primary. Similarly to the other two, this form is also more frequently found in males than in females, and usually begins near middle life.

Considering first heredity, this is a matter of some degree of importance, as in a remarkable family mentioned by Dickinson, in which a pronounced tendency to chronic Bright's disease occurred in four generations. Next comes syphilis. This is held by some to produce chronic Bright's disease, but probably in many cases it is rather due to the mercurial treatment. The third cause mentioned was overeating. The frequency of the disease in the better classes in America is suggestive, and Osler prefers to believe it to result from overeating rather than from alcoholic excesses. It is quite possible in persons who habitually eat and drink too much, the work thrown on the liver is excessive, and the elaboration of certain materials is so defective that, in their excretion from the general circulation, they irritate the kidneys.

The fourth cause—and an important one—is alcohol. The continuous, and even moderate, use of alcohol for many years is a widespread cause of the disease, particularly in conjunction with other factors.

Fifth on the list are those cases secondary to arteriosclerosis. This is by far the most common form in America. It is seen in men over 40 years of age who have worked hard, eaten freely and taken alcohol to excess. They are conspicuous examples of the "strenuous life," the incessant tension of which is first felt in the arteries.

Finally, we consider the primary form, reserved until now because it is probably the most typical of the chronic diseases of the kidney. *With* renal sclerosis it is favored in origin and development by the anxieties, worries and high nervous tension connected with modern business activity and social functions, the latter particularly acting their part among elderly ladies. It is chronic from the onset—a slow, creeping degeneration of the kidney substance, in many respects only an anticipation of the gradual changes which take place in the organ in extreme old age, aptly termed by Dr. Chew "the gray hairs of the kidney."

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THE MEETING OF THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

By Randolph Winslow, M.D.

The twenty-second annual meeting of the Southern Surgical and Gynecological Association was held at Hot Springs, Va., on December 14, 15 and 16, 1909. Hot Springs is a famous thermal resort, situated in Bath county, Virginia. It is reached via the Chesapeake & Ohio Railroad, and one can make the trip without change by securing accommodations in the Pullman car from Baltimore. Hot Springs is not only a summer resort, but it has become also a popular winter resort. It is situated in the Alleghany Mountains at an elevation of about 2500 feet above the sea, and derives its name from the fact that springs of hot water are found in this locality. These springs are very beneficial for rheumatic diseases, and many people seek their aid to rid themselves of rheumatic and gouty affections. The chief hotel is called the New Homestead, and is an enormous building said to contain 800 rooms. It is a popular place for associations of various kinds to meet at, and therefore the Southern Surgical and Gynecological Association, instead of meeting in some large city, held its twenty-second annual session at Hot Springs, the meeting being held at the New Homestead Hotel. A large number of prominent surgeons from the Atlantic to the Pacific Coast and from the Great Lakes to the Gulf of Mexico gathered together to discuss surgical and gynecological conditions. About 45 papers were presented, covering a very wide range of subjects. Dr. R. C. Coffey of Portland, Ore., presented an elaborate experimental work on pancreato-enterostomy in an effort to solve the problem of how to make an anastomosis between the pancreas and the small intestine, where for some reason it may be necessary to remove a portion of the pancreas or to circumvent an obstruction of the pancreatic duct. He has apparently solved the problem, but the method has not yet been applied to human beings. This article of Dr. Coffey's will be found published in *Annals of Surgery* for December, 1909, and is well worth a careful perusal. The subject of pancreatitis, both acute and chronic, claimed considerable attention and will also be one of the prominent matters discussed at the next meeting of the American Medical Association. It is in

the line of advanced surgical thought that cases of chronic pancreatitis, whether due to obstruction of the common bile duct or to infection of the pancreatic and bile ducts, is best treated by performing cholecystenterostomy in order to thoroughly and permanently drain the bile passages into the small intestine. Our friend, Dr. Charles H. Mayo, delivered a very excellent illustrated lecture upon the diagnosis of exophthalmic goitre, or, as he prefers to call it, hyperthryoidism. The scope of this lecture was very similar to those that he delivered at the University of Maryland in November. His associate, Dr. Louis B. Wilson, also gave an illustrated lecture upon hypernephromata. Of 38 cases of malignant tumors of the kidney removed at Mayo Clinic in the last 10 years, 19 of them, or 50 per cent., were hypernephromata. This is, then, the most frequent malignant disease of the kidney, and until recently it has been thought to be a comparatively rare affection. A paper of vast importance, based upon experimental and clinical evidence, was read by Dr. George W. Crile of Cleveland, Ohio, entitled "Clinical and Experimental Research Into Nitrous Oxide and Ether Anesthesia." Dr. Crile demonstrated the great advantage of nitrous oxide and oxygen anesthesia over the methods now in use. Not only is the danger greatly lessened, but the time required for producing complete anesthesia is also reduced to a minimum, being usually a minute and a half to two minutes. The patient wakes up promptly, and a few minutes after the withdrawal of the anesthetic, in possession of all his mental faculties, and does not have subsequently the nausea and vomiting that so frequently accompany chloroform and ether narcosis. It requires, however, a special apparatus, and is at the present time rather more difficult to employ, as well as more expensive. The time is certainly coming when nitrous oxide will be extensively used as a general anesthetic owing to its quickness of action, freedom from danger and absence from those distressing after-effects which accompany other forms of general anesthesia. Dr. F. C. Witherspoon of Butte, Mont., read a paper on "Acute Gastro-Mesenteric Ileus Following Operation for Ulcer of the Stomach." He gave the details of a case upon which he had performed posterior gastrostomy for ulcer of the stomach. The patient did well for nearly two weeks, and then began to vomit and show evidence of obstruction of the new outlet. The lower margin of the stomach was found to reach as low as the pelvic brim, and, in spite of ordinary methods of treatment, the patient's condition grew progressively worse. He reopened the abdomen and found the anastomosis perfect, but the stomach greatly dilated, showing that drainage was not taking place. He therefore performed a gastrostomy, by means of which, through a rubber tube, he was able to keep the stomach empty, and after eight days the stomach had regained its tone to such an extent that it was possible to remove the tube and permit feeding by mouth. The patient made a good recovery. A very excellent presidential address was made by Dr. Stuart McGuire of Richmond, Va., on "Latent and Active Neurasthenia in Its Relation to Surgery." Dr. Walter C. G. Kirchner of St. Louis, Mo., read a paper on "The Treatment of Wounds of the Heart, with Report of Two Cases," one of which recovered and the other proved fatal. Several other cases were also mentioned by other gentlemen in the discussion of the paper. It is evident, therefore, that wounds of the heart are properly treated by surgical intervention, and that when this is done a very large proportion of recoveries will take place. Stab wounds are more favorable for recovery than are gunshot wounds. Dr. Howard A. Kelly of Baltimore presented a paper, with beautiful illustrations by Max Broedel, on an excision to expose the kidney, which is rather different from the one ordinarily employed.

Dr. John Young Brown of St. Louis and Dr. Wm. Engelbach presented a very excellent illustrated address upon the anatomic, pathologic and clinical studies of lesions involving the appendix and right ureter, with specal reference to dagnosis and operative treatment, in which, by means of the ureteral sound and X-ray examination, a differentiation between diseases of the appendix and of the right ureter could be made. Dr. Roswell Park of Buffalo, N. Y., made an address upon the prevalence of cancer, which he says is certainly increasing at a remarkable rate of progress, as is well known. He entertains the view that cancer is a parasitic disease, though up to this time the parasite has not been discovered. Dr. Robert T. Morris of New York, in his characteristic and inimitable style, read a paper on the advantages of neglect in appendicitis operations, the chief point being to operate as quickly as possible, with as little traumatism of the abdominal structures as possible—the avoidance of irrigation of the

abdominal cavity and of handling of the viscera, the employment of small drains, and, as he says, "You run whilst the pus runs." Circumscribed serous spinal meningitis was the subject of a paper presented by Dr. John C. Munro of Boston, Mass., a condition which appears to have been recognized in but a few cases, and which is generally amenable to surgical treatment. Dr. Chas. A. L. Reed of Cincinnati, Ohio, contends for the performance of cecostomy instead of appendicostomy in cases of amebic disease of the intestines, or, indeed, of any septic process located in the large intestine, and it is also claimed by some that this route either through the appendix or through the cecum might be advantageously substituted for the rectum for the purpose of the instillation of normal salt solution instead of as is usually done by the rectum, and it also may be made use of as an avenue for the introduction of liquid food into the large intestine.

Many other very interesting topics were discussed and papers presented, amongst them one by the writer upon "Some Acute Abdominal Conditions in Infants," which was very well received and elicited ample discussion. The next meeting of the association will be held at Nashville, Tenn., under the presidency of Dr. W. O. Roberts of Louisville, Ky.

THE PROFESSORS OF SURGERY IN THE UNIVERSITY OF MARYLAND.

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

No. 5.—Christopher Johnston, M.D.

In 1860 Professor Smith resigned the chair of surgery and was made professor of the surgery of the skeleton, and Dr. Christopher Johnston was elected professor of the principles and practice of surgery. He was descended from Scotch ancestry, and was born in Baltimore September 27, 1822. His academic education was received at St. Mary's College, and he began the study of medicine in the office of Dr. John Buckler. He received the degree of M.D. at the University of Maryland in 1844, and soon thereafter visited Europe and traveled extensively. From 1853 to 1855 he was again in Europe, and spent much time in the hospitals of Paris and Vienna. On his return he was elected lecturer on experimental physiology and microscopy. In 1857 he became professor of anatomy in the Baltimore College of Dental Surgery, which position he held until 1864, when he was made professor of anatomy and physiology in the university. As stated above, in 1869 he succeeded Professor Smith in the chair of surgery and held this position until 1881, when he resigned and was made emeritus professor of surgery, which title he retained during the rest of his life. Dr. Johnston was a highly educated and cultured gentleman with a strong taste for scientific study and research. He was an accomplished linguist, speaking several languages with fluency; he had a fine command of the English language and was an exceedingly entertaining lecturer to those who had sufficient education to be able to appreciate his style, but to those who were deficient in education he was not a lucid or entertaining teacher. He was a skilled microscopist, and did in his early life much excellent scientific work in this direction, which attracted wide attention both in this country and abroad. One of his earliest papers was on the "Auditory Apparatus of the Mosquito," which was published in the *London Quarterly Journal of Microscopical Science* in 1855. He was not a prolific writer, but contributed a number of articles to scientific and medical journals, his most pretentious work being an article upon "Plastic Surgery" in the *Ashhurst International Encyclopedia of Surgery* in 1881. He was a neat and painstaking surgeon, and gave special attention to detail and cosmetic effect. He was the first in Maryland to perform complete removal of the upper jaw. He operated for exstrophy of the bladder, and had a large experience in tracheotomy for various conditions. After the battle of Gettysburg he rendered valuable service to soldiers wounded in that sanguinary conflict, and this appeared to be the turning point in his career, as from that time he became widely known and esteemed as a physician and surgeon in Baltimore, and for many years prior to his death was the leading physician of the city. Dr. Johnston was a tall, well-proportioned man of striking appearance. His head was large and covered with a full growth of reddish hair, and he also wore a full beard of similar color. He was very formal in his manners and often quaint of speech; he possessed a wide fund of anecdote, and his addresses were frequently enlivened with witty sallies. He was a man of the highest personal and professional integrity, and was a great ornament

both to his profession and the university. He was president of the Medical and Chirurgical Faculty of Maryland, the Academy of Sciences and of many of the local societies of the city. He was also a member of the American Surgical Association and of various other national societies. He visited Europe five times, and added to his knowledge of his profession as well as to his general culture by the result of his observations on these occasions. He died on October 11, 1891, and although he had been for some time more or less removed from the activities of his profession, he was held in the highest esteem by his confrères and by the people.

CORRESPONDENCE

Cotabato, Mindanao, P. I., Nov. 1, 1909.

The Hospital Bulletin Co.,

Baltimore, Md.:

Gentlemen—A number of our alumni, now members of the Army Medical Corps, are serving tours of duty—of two years' duration—in these possessions, and it has occurred to me to mention them and their work as a possible source of interest to those of your readers who happen to have known them during 'varsity and hospital days.

The Chief Surgeon of the Philippines Division, the senior medical officer who directs the policy of our department throughout the archipelago—a position involving considerable responsibilities—is Col. Louis W. Crampton of the class of '69. As he is on the staff of the commanding general, his headquarters are in Manila.

Major Wm. F. Lewis of the class of '93 is the senior medical officer at Jolo, which, with its mixed command of cavalry, infantry and field artillery, is one of our largest and most important military posts.

Another member of the same class is Major Jere B. Clayton, whose station is Zamboango, a most desirable station and the headquarters of this department (of Mindanao), where he has just brought to a successful conclusion a very trying campaign against an epidemic of Asiatic cholera.

At Los Banos, up in Luzon, where the army has taken advantage of the natural hot springs existing there to establish a sanitarium for the treatment of rheumatic and other affections benefited by this type of hydrotherapy, we find Capt. Perry L. Boyer of the class of '99.

The class of 1900 is represented by Capt. Chas. C. Billingslea, one of the fortunate few with station in Manila.

W. L. Hart, '06—one of my classmates—is also, like myself, a recent arrival from the States, and has been assigned to duty at Cebu, a large exporting point. He writes me that he likes the station so well that he is hoping the authorities will forget him for at least a year. We both have rank in the junior grade, that of first lieutenant, but he will attain his captaincy in two and I in three years' service.

In the matter of assignments I have no cause to complain. Here we have a good variety of interesting medical and surgical cases, and, aside from the professional viewpoint, a sojourn in Moroland, where the inhabitants are all disciples of Mohammed and an interesting people, occupying one of the most beautiful and fertile islands in this group, is well worth while.

My very best wishes for the success of THE BULLETIN.

Very truly yours,

A. D. TUTTLE,
First Lieutenant, Medical Corps.

THE PART THE UNIVERSITY OF MARYLAND PLAYED IN THE OPHTHALMOLOGICAL DEVELOPMENT IN AMERICA.

William Gibson, another eminent surgeon who thought and acted for himself, and who contributed materially to ophthalmologic knowledge and practice (Hubbell, "The Development of Ophthalmology in America"), was the successor to Physic in the chair of surgery in the University of Pennsylvania, to which he was called in 1819. He was born in Baltimore in 1788, and died in Savannah, Ga., in 1868. He graduated in arts in 1806 from Princeton College with high rank as a classical scholar. He then repaired to Edinburgh, where he studied medicine under John Bell, graduating in medicine from the university of the city in 1809. From there he went to London, where he studied for some time under Sir Charles Bell. From London Dr. Gibson returned to Baltimore, and was soon in successful practice. He was appointed professor of surgery in the medical department of the University of Maryland in 1812. He occupied this position till he removed to Philadelphia in 1819. His connection with the University of Penn-

sylvania continued until 1855, when he resigned. Dr. Gibson was the first to ligate the common iliac artery in 1812, but his greatest feat, a feat which made his name widely known, both in Europe and in this country, was the performance of Cæsarean section twice on one woman, saving mother and child in both instances. His reputation as an expert operator extended far and wide, and while at times his ill-temper betrayed him into unkind expressions, yet he never failed to command the highest respect of most of his confréres. He was an able and impressive teacher, his characteristic qualities being clearness, accuracy and earnestness. He made no pretensions to eloquence. Dr. Gross in his sketch of him says: "He handled his knife with great skill, and was one of the foremost operators of his day." Dr. Gibson made many contributions to the practice and literature of general surgery, and some to the surgery of the eye. His most noted literary production was his "Institutes and Practice of Surgery," the first edition of which was published in 1824; the last, the eighth, in 1850. The first volume of this work contains an excellent résumé of the diseases of the eye and their treatment, in which is embodied the undoubted results of the experience and study of a man versed in the ophthalmology of his time. His discussion of cataract is especially authoritative. He was the first surgeon to perform the operation for convergent strabismus, which was afterward made so popular by Dieffenbach. Unfortunately, he did not record his operation in time to receive due credit for priority. Dr. M. D. Reese, in 1842, in his supplement to the "Surgical Dictionary" of Samuel Cooper (p. 127), refers to strabismus operation thus: "It appears from the 'Institutes of Surgery' that Professor Gibson attempted the cure of strabismus by dividing the recti muscles of the eye precisely as now practiced, some 20 years since in Baltimore. Soon after he repeated it unsuccessfully in Philadelphia in several cases, and was induced to abandon it by the unfavorable opinions expressed on the operation by Dr. Physic. He, however, inculcated the propriety of the operation on his class many years since, and Dr. A. E. Hosack of New York, then one of his pupils, distinctly recollects Dr. Gibson's expressions of confidence that the operation would ultimately succeed."

Dr. Gibson himself, in the sixth edition of his "Institutes of Surgery," published in 1841, describes in detail the operations which he performed in 1818, and also adds that on the advice of Dr. Physic he was led to abandon these experiments. His reference to the subject will be found on page 375 of his work.

In 1821 he described an instrument for cutting to pieces the crystalline lens in all cases of cataract. It was a pair of scissors, thus described: So delicate as hardly to exceed, in size, the iris knife of Sir William Adams, and at the same time so strong and sharp as to cut with ease the most solid and compact lens and capsule, without injuring in the slightest degree any part of the eye. These scissors are formed on the principle of Mr. Willaston's scissors, used for common purposes, with the edge so constructed as to operate like a knife. On this account the instrument perforates the coats of the eye with the utmost facility, and when introduced the blades can be opened to a certain extent, so as to cut the lens to pieces without bruising it or any other part, the necessary effect of scissors as they are usually made. This instrument possesses another advantage—the lens is supported in its natural situation during the operation by having one blade behind and the other before it, so that it may be cut to pieces, in situ, and its remains afterward forced, by the shut blades, into the anterior chamber, for dissolution.

At the time Dr. Gibson suggested this instrument, dissolution of cataract had become a popular method of operating through the influence of Saunders and Adams of London, and the scissors were offered as a substitute for needles, the use of which was frequently attended by dislocation of the lens into the vitreous humor.

Dr. Gibson's originality was further illustrated by another method which he adopted for the absorption of cataract. It consisted in passing a common sewing needle, slightly curved and armed with a single thread of silk, through the sclera about two lines from the cornea, through the opaque lens and sclera of the opposite side at a point corresponding to the one at which it was introduced, the pupil having been previously dilated with belladonna. The silk being drawn through and the ends cut off, a single thread was thus left passing through the ball of the eye and acting on the diseased lens in the manner of a seton. Dr. Gibson operated in this manner on three cases. In two no reaction or accident intervened, and at the end of 10 days, in both cases, the diseased lens had disappeared. The silk was then withdrawn and in a few days the vision was restored. In a third case

in which this operation was performed it failed in consequence of the iris being wounded and the thread was withdrawn at an early period because of inflammation. The wound of the iris was attributed to not using belladonna.

Although Dr. Gibson's reputation rested upon his general surgical work, from the foregoing notations it can be readily seen that he was to some extent a pioneer in ophthalmic surgery, and had a keen insight into ocular surgery as it then existed.

ABSTRACTS

Constitutional Conditions Affecting Nasal Catarrh.

Dr. Charles W. Richardson (*Monthly Cyclopedia and Monthly Bulletin*, October, 1909) desires to call particular attention to the subtle influences that certain conditions, unattended with any organic change, exert upon the mucous membrane of the nose, throat, and even the bronchial mucous tract. The local manifestations of these disturbances are in the form of vascular changes in the turbinal tissues. He divides them into three groups: (a) Paroxysmal form of vasomotor turgescence of the nasal mucosa, occurring occasionally at periods during the day, more frequently at night. (b) A more or less constant type of vasomoter turgescence of the nasal mucosa, which is most intense during the night. (c) A vasomoter turgescence of the nasal mucosa occurring at night, and which is attended with a similar condition in the bronchial tract, as evidenced by coughing and wheezing.

The etiology in each instance is essentially nervous, superinduced by unhygienic methods of living and working. They are the result of overworking the whole nervous system, which is followed by impairment of the harmony of action of the vasomoter system.

The rational treatment of these cases is hygienic and the mildest of local washes and applications. Cauterization and turbinotomy have no part in the cure of these conditions, according to the author.

Dr. Charles A. Wells, class of 1862, recently elected State Senator from Prince George's county, Maryland, was tendered a reception by the Democracy of Chillum, Bladensburg and Hyattsville districts at Hyattsville November 13, 1909.

Dr. Henry Weinberger, class of 1908, superintendent of the Maryland Homeopathic Hospital, has resigned, the resignation to take effect December 12, 1909, to accept a position on the staff of St. Gregory's Hospital, New York.

Dr. J. Clement Clark, superintendent of Springfield State Hospital, in his annual report to the board of governors reports that there are 537 male and 409 female patients in the institution, and whose general health is good.

Dr. R. C. Massenburg of Towson is able to get about again, after a week's illness.

Dr. and Mrs. J. Fred Adams, who spent the summer and early fall at their country home on the Rolling road, near Catonsville, have reopened their city home, 1314 N. Charles street, for the winter.

The following alumni are located in New York city:

Dr. J. Bissell Dougal, class of 1888, 49 W. 38th street.

Dr. Robert F. Chapman, class of 1865, 121 W. 120th street.

Dr. William T. Dawson, class of 1880, 766 West End avenue.

Dr. William A. E. McKee, class of 1883, 208 East 73d street.

Dr. Edward L. Meierhof, class of 1881, 1140 Madison avenue.

Dr. George A. Taylor, class of 1890, 46 West 36th street.

Dr. J. Dubois Van Derlyn, class of 1894, 174 East 71st street.

Dr. Felix Villamil, class of 1903, 342 E. 30th street.

Dr. Ejnar Hansen, class of 1904.

Dr. Clarence Benson, Columbus Hospital.

Dr. William W. Hala, class of 1905.

Dr. Joseph A. Devlin, class of 1906, St. Francis Hospital.

ITEMS

Dr. Charles D. Baker, class of 1882, was born near Frederick City, Md., September 8, 1857. He received the degree of B.A. in 1879 and M.A. in 1882 from Lebanon Valley College, Annville,

Pa. He resides at Rohrersville, Washington county, Maryland.

Dr. William Hewson Baltzell, class of 1889, is a son of the late Dr. William Hewson Baltzell, class of 1843. He was born at Baltimore January 23, 1858. From 1890 to 1893 he was a resident surgeon in the Johns Hopkins Hospital. Until recent years he lived in Baltimore, but is now a resident of Wellesley, Mass.

Dr. G. Irwin Barwick, class of 1894, was born in Kent county, Maryland, March 28, 1869. In 1891 Western Maryland College confered the degree B.A. upon him and later the M.A. He resides at Kennedysville, Kent county, Maryland.

Dr. Joseph Edward Beatty, class of 1861, of Baltimore, formerly of Middletown, Md.; physician and surgeon, ex-surgeon United States Army and a general practitioner of medicine for 48 years, was born at Frederick City, Md., July 11, 1839. In 1855 he graduated from Frederick Academy, and later entered the medical school of the University of Maryland, whence he graduated in 1861. He immediately entered the United States service with the rank of assistant surgeon; in 1862 he was promoted to surgeon, and in 1865 he was made division surgeon of the Ninth Army Corps. Since the close of the war he has engaged in general practice, first in Middletown, then at Baltimore. In 1899 Dr. Beatty became a member of the Medical and Chirurgical Faculty.

Dr. Samuel Lee Magness, class of 1902, of Baltimore, is a native of this city. He was born November 27, 1877, and is a son of Mr. Moses N. Magness and Mary E. Chaney, his wife. His earlier education was obtained in a school at Wetheredville, Baltimore county, and private instruction. In 1898 he matriculated in the medical department of the University of Maryland, and was graduated with the degree of M.D. in 1902. After graduation he was appointed assistant resident physician, Bayview Hospital, where he served a year, since which time he has engaged in private practice in Baltimore. In 1905 he was elected professor of chemistry in the Baltimore University. On October 20, 1904, Dr. Magness married Miss Stella F. McConnell.

Dr. Samuel Jones Belt, class of 1876, is a resident of Baltimore. He was born in Prince George county October 6, 1844. In 1868 he graduated from the Maryland College of Pharmacy, now the pharmaceutical department of the University of Maryland, with the degree of Ph.G., and in 1876 had the degree of M.D. conferred upon him by the medical department of the University of Maryland.

Dr. Benjamin Robert Benson, class of 1873, is a general practitioner of medicine at Cockeysville, Md., where he has been prominent in professional circles for more than 30 years. He is a native of Blackrock, Baltimore county, Maryland. He was born January 6, 1854, and is a son of Rev. Joshua L. Benson and Rachel Jane Miller Benson. His literary education was obtained in public schools in the Fifth district of Baltimore county and Milton Academy at Philopolis, Md. In 1870 he entered the medical department of the University of Maryland, and was graduated from there in 1873 with the degree of M.D. He then served a year's interneship in the hospital. At the expiration of this period he formed a copartnership with Dr. C. Wells of Hampstead, Carroll county, Maryland, which relationship he maintained until December, 1873, when he located at Bruceville, Carroll county, Maryland, where he remained until March 31, 1875. On April 1, 1875, he opened an office at Cockeysville, Md., where he has since lived and where he has come to be recognized as one of the leaders of the medical profession of that part of the county. Dr. Benson has served four years as school trustee. He is a member of the Methodist Episcopal Church. He joined the Medical and Chirurgical Faculty in 1885. He is also a member of the Baltimore County Medical Society. In 1877 Dr. Benson married Mary Elizabeth Aseneth Armacost of Waverly, Md., by whom he has six children—Carroll Price, Beulah Miller, Benjamin Robert, Jr., Clarence Erving, Emory Wilhide and Mattice Elizabeth Benson. He is a brother of Joshua Edward Benson, class of 1884, who was born in Baltimore county September 7, 1860, and who also practices at Cockeysville. He has two sons in the medical profession and both graduates of the medical department of the University of Maryland—Dr. Benjamin Robert, Jr., class of 1907, and Dr. Clarence Erving, class of 1909, at present a resident physician in Columbus Hospital, New York city. Dr. Benson has always

had a warm spot in his heart for his alma mater, and is one of its staunchest and most loyal friends.

These alumni attended the meeting of the Maryland Psychiatric Society, held at Mount Hope Tuesday, January 4, 1910: Drs. Frank J. Flannery, J. Clement Clarke, Frank J. Keating, N. M. Owensby, W. F. Swartz and W. S. Carswell. Dr. J. Clement Clarke was appointed to the committee on the after-care of the insane.

Dr. Edward Warren, the son of Dr. William C. Warren, was born in Tyrrell county, North Carolina, in 1828. He received his literary education at the University of Virginia, and obtained the degree of M.D. from the same institution in 1850, and a year later also at Jefferson Medical College, Philadelphia. He then began practice at Edenton, in his native State. He spent the year 1854-1855 in Paris attending the hospitals there. He returned to Edenton in the latter year and resumed practice as the partner of his father. In 1856 he gained the Fisk Fund Prize of the Rhode Island Medical Society for an essay on "The Influence of Pregnancy on the Development of Tubercular Phthisis." About this time he edited the *Medical Journal of North Carolina*. In 1860, a vacancy having occurred in the medical faculty of the University of Maryland through the death of Prof. Charles Frick, he applied for and obtained the chair of materia medica and therapeutics. In January, 1861, he founded a medical journal in Baltimore, called the *Baltimore Journal of Medicine*. This was a bi-monthly, and only three numbers appeared. By that time the Civil War had begun, and Dr. Warren went South. Between 1861 and 1865 he held medical offices under the State of North Carolina and the Confederate States, viz., Surgeon-General of the former and Medical Inspector of the Army of Northern Virginia in the latter. In 1863 he published at Richmond a 12mo entitled "Epitome of Practical Surgery for Field and Hospital." After the close of the war he returned to Baltimore and demanded the restoration of his chair at the university. This was refused on the grounds that he had voluntarily abandoned it, and though repeatedly notified to return, he had declined to do so, and that his continued absence and the interests of the school had rendered it necessary to fill so important a chair, to which, though the circumstances had warranted earlier action, the faculty had yet postponed making a permanent appointment until the session of 1863-64 (Professor McSherry being appointed). Although Dr. Warren indulged in some threats, he did not put them into execution, but sought revenge by founding a rival college. In furtherance of his design he had address to obtain liberal aid from the city and State, and large classes were at once obtained by a beneficiary system admitting disabled soldiers from the South at nominal rates. By these means he reorganized Washington University, a former rival of this university, but suspended since 1851. From 1868 to 1870 he edited a semi-monthly medical journal called the *Medical Bulletin*. In 1871, owing to differences of opinion as to the management of the affairs of his school, Dr. Warren resigned and joined with Drs. Byrd, Opie and others in founding another college, the College of Physicians and Surgeons, in which, as well as in the former, he occupied the chair of surgery. In 1873 he sought and obtained an appointment in the Egyptian service and set out for Cairo. He remained in that country until 1875, holding the rank of Surgeon-in-Chief of the War Department. In that year he suffered so much for ophthalmia that he was compelled to seek a furlough. He did not return to Egypt, but settled in Paris, where he practiced as a licentiate of the University of France. Dr. Warren was honored by the University of North Carolina with the degree of LL.D. In 1885 he published, under the form of a series of letters to Dr. John Morris of Baltimore, an interesting autobiography, "A Doctor's Experiences in Three Continents." Dr. Warren was a fluent speaker and graceful writer. He died at Paris September 16, 1893. (Historical Sketch, University of Maryland, Cordell.)

Dr. Marshall L. Price, class of 1903, is secretary to the State Board of Health of the Commonwealth of Maryland.

Dr. Watson S. Rankin, class of 1901, is secretary of the North Carolina State Board of Health.

Dr. Charles Frederick Williams, class of 1899, is secretary of the South Carolina State Board of Health.

Dr. A. A. Matthews, class of 1900, of Spokane,

Wash., is surgeon to St. Luke's Hospital, Spokane.

Miss Nettie Flannagan, formerly superintendent of the University Hospital Training School for Nurses, occupies the same position at St. Luke's Hospital, Spokane, Wash.

The last regular meeting of the University of Maryland Medical Association was held in the amphitheater Tuesday, December 14, 1909, at 8.30 P. M. The program was as follows:

Symposium on nephritis:

1. Etiology—Mr. O'Neal, class of 1910.
2. Pathology—Dr. R. B. Hayes.
3. Symptoms and diagnosis—Dr. C. W. McElfresh.
4. Treatment—Dr. Joseph Gichner.

The meeting was well attended and the papers were thoroughly enjoyed by those present.

Dr. John T. O'Mara is president of this society, and Dr. S. Demarco of 1604 Linden avenue, Baltimore, secretary. All are invited to these meetings. Visitors are welcome. The meeting night is the second Tuesday of each month.

Dr. J. W. Williams made the presentation address upon the occasion of the presentation of the portrait of Dr. F. E. Chatard to the Medical and Chirurgical Faculty Tuesday, December 7, 1909.

At the meeting of the Section on Clinical Medicine and Surgery, Baltimore City Medical Society, Medical and Chirurgical Hall, Friday, December 3, 1909, Dr. Hiram Woods read a paper on "A Case of Serous Meningitis Following Otitis Media; Operation; Recovery;" and Dr. A. G. Rytina, "The Spirocheta Pallida—Some of the Practical Benefits Resulting from Its Discovery."

The following of our alumni have been vice-presidents of the Medical and Chirurgical Faculty:

1848-1849—Peregrine Wroth, class of 1841.
1850-1851—Joel Hopkins, class of 1815, and Peregrine Wroth, class of 1841.
1853-1854—John Fornendin, class of 1823, and Peregrine Wroth.
1854-1855—George C. M. Roberts, class of 1826; Samuel P. Smith, class of 1817, and Joel Hopkins, class of 1815.
1855-1856—George C. M. Roberts and G. W. Miltenberger, class of 1840, and M. Diffenderfer, class of 1833.
1856-1857—P. Wroth, Samuel Smith and W. H. Davis, class of 1833.
1857-1858—William Waters, class of 1824; Frederick Dorsey, class of 1824, and Joel Hopkins.
1858-1859—Samuel Chew, class of 1829, and Samuel Handy, class of 1821.
1871-1872—C. H. Ohr, class of 1834, and Edward Warren, professor of materia medica and therapeutics.
1873-1874—Samuel C. Chew, class of 1858, and H. M. Wilson, class of 1850.
1874-1875—Prof. Francis T. Miles and James A. Steuart, class of 1850.
1875-1876—Christopher Johnston and J. C. Thomas, class of 1854.
1876-1877—P. C. Williams, class of 1851; James A. Steuart and Francis T. Miles.
1877-1878—S. C. Chew and F. E. Chatard, class of 1861; Charles H. Jones, class of 1851.
1878-1879—J. C. Thomas and L. McLane Tiffany, class of 1868.
1879-1880—H. P. C. Wilson, class of 1851, and James A. Steuart.
1880-1881—L. McLane Tiffany.
1881-1882—A. H. Bayly, class of 1835, and I. E. Atkinson, class of 1865.
1882-1883—Thomas S. Latimer, class of 1861, and Richard McSherry, class of 1880.
1883-1884—J. S. Lynch, class of 1853.
1884-1885—L. E. Atkinson.
1885-1886—E. C. Baldwin, class of 1844, and J. E. Michael, class of 1873.
1887-1888—Charles H. Jones and James Carey Thomas, class of 1854.
1888-1889—J. E. Michael.
1889-1890—T. A. Ashby, class of 1873, and C. G. W. Macgill, class of 1856.
1890-1891—George H. Rohé, class of 1873.
1891-1892—J. W. Humrichouse, class of 1873.
1892-1893—J. W. Downey, class of 1869.
1893-1894—John S. Fulton, class of 1881.
1894-1895—Charles W. Jones.
1896-1897—Wilmer Brinton, class of 1876, and Randolph Winslow, class of 1873.
1897-1898—W. F. A. Kemp, class of 1872.
1899-1900—Samuel Theobald, class of 1867.

1900-1901—Samuel T. Earle, class of 1870, and J. B. R. Purnell, class of 1850.

1902-1903—Samuel T. Earle and Wilmer Brinton.

1903-1904—James M. Craighill, class of 1882.

1904-1905—Samuel T. Earle and Julius A. Johnson, class of 1871.

1905-1906—Charles O'Donovan, class of 1881, and Thomas M. Chaney, class of 1866.

1906-1907—William T. Watson, class of 1891.

1907-1908—Roger Brooke, class of 1887; Henry L. P. Naylor, class of 1860, and George Dobbin, class of 1894.

1909-1910—Compton Riely, class of 1897.

At a special meeting of the Medical and Chirurgical Faculty, 1211 Cathedral street, Thursday, December 16, 1909, Dr. N. R. Gorter read the "Report of the Committee on Pure-Food Law."

At the annual meeting of the Baltimore City Medical Society, Tuesday, December 7, 1909, Dr. Charles W. Mitchell was elected vice-president. During the meeting a portrait of Dr. N. G. Kierle was presented to the Faculty by Dr. Harry Friedenwald, and also a book by Dr. Kierle entitled "Studies in Rabies." Dr. Kierle was honored by his alma mater at the centennial commencement with the degree of Doctor of Science (honorary). Dr. Kierle has been a credit to his alma mater. His contributions to our knowledge of rabies has been of inestimable value to the medical profession.

Dr. A. M. Shipley has been made a member of the House of Delegates of the Medical and Chirurgical Faculty.

Dr. Thomas J. Talbott has been made chief of the gynecological laboratory, Maryland Medical College.

Dr. Albert Levy has been made chief of the physiological work at the Maryland Medical College.

Dr. Eugene Kerr is occuping his new home at Glencoe, Md.

Dr. R. B. Hayes has been made a member of the board of governors of the North Carolina Society of Maryland.

Dr. Nicholas L. Dashiell has removed to 2927 St. Paul street, Baltimore, Md.

The resident physicians of the University Hospital gave a dance Tuesday, January 5, 1910, at the Lyceum Parlors to the nurses of the hospital. This affair is known as the annual New-Year dance. Heretofore it has been held at the hospital.

Dr. Isaac C. Dickson, class of 1897, is located at 3022 West North avenue, Baltimore, Md.

Dr. James A. Zepp, class of 1887, of 3050 West North avenue, Baltimore, Md., has retired from active practice. He has been succeeded by his nephew, Dr. Herbert E. Zepp, class of 1904.

On December 27, 1909, the members of the Health Department, Baltimore, Md., tendered Dr. James Bosley, the Health Commissioner, a dinner at the Hotel Caswell. This is the ninth annual dinner which has been given by the members of the department in honor of the Health Commissioner. Dr. William Royal Stokes responded to a toast. Amongst our alumni present were Drs. T. W. Clark, George W. Hemmeter, R. A. Warner, H. K. Gorsuch, Henry H. Hahn, L. J. Turlington, C. T. Buckner, V. F. Kelly, H. W. Stoner, Marshall L. Price, W. P. Stubbs and M. G. Smith.

Dr. George Wells, class of 1867, of Annapolis, Md., Clerk of the Anne Arundel Circuit Court, Chairman of the Democratic County Central Committee and many years leader of his party in the county, is ill with pneumonia. Dr. Wells is 65 years of age, and though he has always been a man of strong constitution, fears are entertained as regards the outcome. Dr. Walton H. Hopkins is in attendance.

Dr. Louis B. Henkel, Jr., is secretary of the Anne Arundel County Medical Society.

Dr. Randolph Winslow read a paper, "Goitre," before the Anne Arundel County Medical Society at Carvel Hall Hotel, Annapolis, Md., Tuesday, January 11, 1910.

Dr. Herbert Harlan read an address, "Conjunctivitis—Its Causes, Prevention and Cure," before the annual meeting of the Anne Arundel County Medical Society January 11, 1910.

Dr. William Royal Stokes presented a paper entitled "Opsonins and the Opsonic Index" before the Anne Arundel County Medical Society January 11, 1910.

The will of Dr. Thomas P. Sappington of Unionville, Md., has been filed for probate. The testator bequeaths all of his property, except the house in Unionville in which he resided and the furniture contained therein, to his son, Dr. Clifford T. Sappington, and brother, Greenbury Sappington, as trustees, to collect the income from the estate and pay the proceeds therefrom, annuany, one-third to the testator's widow, one-third to his son, Dr. Clifford T. Sappington, and one-third to his daughter, Claire Sappington, wife of Dr. James Sappington of Libertytown, Frederick county. Upon the death of the widow the trust is to cease, and the executors, who are the same as the trustees, are to dispose of the estate as follows: To Dr. C. T. Sappington is to be given a 300-acre farm in Carroll county and a farm of about 100 acres between Libertytown and Mapleville; to the daughter, a farm of 200 acres near Mt. Airy. All other property is to be converted into cash and divided equally between the two children. Dr. Sappington, Sr., as well as Dr. Sappington, Jr., graduated from the medical department of the University of Maryland.

Dr. William Hand Browne, class of 1850, fell on the ice in front of Calvert Station, Baltimore, recently, while on his way to take a train for his home at Sherwood, and broke his left arm. His condition is reported as favorable. Dr. Browne is professor of Old English in the Johns Hopkins University and is one of our most distinguished alumni as well as one of the oldest living.

Dr. E. G. Ballenger, class of 1901, recently paid Baltimore a hurried visit. Dr. Ballenger resides at Atlanta and is editor of the *Journal-Record of Medicine.*

Dr. Harry Naylor, class of 1900, and Mrs. Naylor have returned from their wedding trip and are occupying their new home at Pikesville.

MARRIAGES

Dr. Louis Cotten Skinner, class of 1901, of Greenville, S. C., was married Wednesday evening, December 29, 1909, at the Methodist Episcopal Church South, Oxford, N. C., to Miss Daisy Elizabeth Minor, daughter of Mrs. Richard Van Buren Minor of Oxford. After graduating, Dr. Skinner was for a short time a resident physician in the University Hospital, but was compelled to resign owing to ill-health. As a student he was very popular with the members of his class, and was an excellent student, being one of the honor men. He is a member of the Phi Sigma Kappa fraternity.

Dr. Henry Alan Naylor, class of 1900, of Pikesville, Md., son of Dr. Henry L. P. Naylor, class of 1860, of the same town, was married Friday, December 3, 1909, at Ascension Protestant Episcopal Church, Baltimore, to Miss Louise Requardt, daughter of Mrs. John J. Requardt of 1520 Linden avenue, Baltimore. The ceremony was performed by Rev. Robert S. Coupland. Immediately after the ceremony Dr. and Mrs. Naylor left for New York, where they embarked for Jamaica. After their return they will reside at Sudbrook avenue, Pikesville. After graduating, Dr. Naylor was for a year resident gynecologist in the University Hospital.

Dr. T. Morris Chaney, class of 1906, formerly of Chaney, Md., now of Old Fort, N. C., was married recently to Miss Myrtle McComless of Asheville, N. C.

DEATHS

Dr. Thomas Pearre Sappington, class of 1869, one of the best-known physicians of Frederick county, died December 8, 1909, of Bright's disease, aged 62. Dr. Sappington was born at Unionville, Frederick county, Maryland, and was a son of the late Dr. Greenbury Ridgely Sappington, class of 1843. He was graduated in medicine from the University of Maryland in 1869, and for over 40 years practiced his profession. He was widely known in his section and universally respected. He is survived by a widow, formerly Miss Emma Worman; a son, Dr. Clifford Sappington, class of 1903, and a daughter, Mrs. James Coale Sappington, wife of Dr. James C. Sappington, class of 1900.

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REPORT OF NINE GOITRE CASES AND ONE CASE OF ABSCESS OF THYROID GLAND.

By A. Aldridge Matthews, M.D.,
Spokane, Wash.

There have been in the last 30 or 40 years great strides made in the surgical treatment of goitres. From a mortality of about 40 to 50 per cent. it has been reduced to about 5 per cent., and some individual percentages have been reduced to ½ to 1 per cent. (Kocher and Mayo.)

The medical treatment for the goitre at present is not very satisfactory and nearly always useless, but I do not mean to disapprove of all medical treatments in these cases, for in many cases I think they should be given a medical course of treatment and see if they can be helped; especially the severe exophthalmic cases always should be kept under observation and treated to get them in better condition before an operation.

The operations practiced today for goitre are ligation of the superior thyroid arteries, enucleation and partial excision. The dangers accompanying this operation is the removal of too much or all of the gland, which could cause myxedema: injury or removal of the parathyroid bodies, and thereby tetany developing; hemorrhage, infection and injury to the recurrent laryngeal nerve. The percentages of cure in exophthalmic goitres vary very much in different hands, but, as a whole, about 60 per cent. are cured, 25 per cent. improved and the remainder unimproved are suffering from relapses, and I am unfortunate enough to have a case which is suffering from a relapse; at least she never entirely recovered, although was wonderfully improved, this being case No. 4, which I will take up later in more detail.

The technique in operation—I will not go into detail, but will give a brief outline. The patient is placed in the reverse Trendelenberg position, previously having been prepared for the operation, and the neck is now again prepared, the transverse collar incision being used, passing through the skin and platisma muscle, the flap being dissected up, exposing the sterno-hyoid and thyroid muscles, which are retracted back. These muscles are sometimes cut high up when a better view of the field of operation is wanted, but I have not found this necessary in any of these cases which I am reporting. The tumor is now plainly in view; the capsule is split longitudinally and the gland removed. I always use drainage in all of my cases and an excessive drainage in my exophthalmic cases, the anesthetic used being always ether. While it is advised by Kocher and others to use cocaine, I have never been able to convince myself that it is as safe as a general anesthetic, and it is not as comfortable for the patient or the operator. We can hardly anesthetize the field of a large goitre with less than one-half to one grain of cocaine. I have seen severe intoxications and very severe results arise from one-quarter of a grain. It is true these individuals possibly have idiosyncrasies to the use of this drug, but how can we tell which of these individuals might be the one to have this idiosyncrasy? I think that the records will show the ratio of deaths from cocaine to be greater than that of either anesthesia, especially in these cases. I think the surgeons of this country as a whole prefer the general anesthetic in preference to the local, for we can have a very much better view in the field of operation under a general anesthetic, and do the work more easily and more rapidly.

One very difficult thing to determine is how much gland to remove in the hyperthyroidism cases. After removing a certain portion of the gland, and our patient is not cured, but improved, that means that we did not remove enough gland, and a second operation is necessary, which should lead to a cure. We cannot be governed by the size of the gland, for we may have a very large gland with very little hyperthyroidism, or a hypo-

thyroidism and a very small gland with much hyperthyroidism; so the size of the gland has no special bearing in this matter, and one has to judge for himself in each individual case as to how much gland to leave and how much to take away.

The first four of these cases were of the exophthalmic variety—one fibro-adenomatous, three cystitic and one parenchymatous in character—and I here submit a brief history of each of these cases.

I wish to take this opportunity to thank Dr. E. L. Kimball for case No. 2, this case being under his service and we both being intimately associated.

In case No. 1, the only fatal case of this number, I have often regretted that I operated, not that the outcome would have been any different from what it was, but I am afraid it hurried her death a little. I was not especially inclined to operate, but was urged into the matter by the consultation of two other physicians as being the only possible chance to save her life. Cases 2 and 3 made perfect recoveries, and from recent reports they are well and enjoying good health.

Case No. 4, after leaving the hospital, improved slowly for about two months, and then her condition began to reverse itself. I have had her under observation ever since the operation on account of her slow recovery. Up until about the first of September she was improving, but since she is slowly relapsing into the old condition, and I have advised the removal of more of the gland, which she has consented to have done in two weeks if her condition does not improve by that time. On the 22d of September her pulse-rate was 95, the exophthalmic condition being quite noticeable, but by no means as marked as it was at the time of her operation. She also complains of having a watery diarrhea and attacks of vomiting, which sometimes come on without warning. Her nervous condition is good, except that she complains of a little difficulty in sleeping. The right upper angle which I left has enlarged to about twenty times the size of the original piece I left at the operation. The left lobe is apparently in normal condition; there is no enlargement at present, but at the time of operation it was of considerable size.

Case No. 10, being a case of an abscess in thyroid gland, which is quite unusual, and for that reason I wish to place it on record, there being no special interest otherwise in it.

Case No. 1.—Mrs. G., age 32, white, female, married, Jewess; admitted to the hospital January 2, 1905; pulse, 138; respiration, 28; temperature, 99°; family history negative.

Past History.—Negative as regards her present trouble.

Present Trouble.—Noticed a swelling on the interior part of the neck about 18 months ago, which gradually increased for about six months and then remained that size for a few months. During this time she was taking medicine and applying the ointment prescribed to her by her family doctor. She did not know the nature of the medicine and she did not think it had any effect upon the tumor, which was at this time about the size of a large flat biscuit on either side of the median line of her neck. At present there is a large bilateral, pulsating tumor about the size of a half grape fruit on either side, with large pulsating veins on the external surface, and a decided thrill which can be felt and heard over and around this tumor.

The eyes protruded greatly, and her sight is considerably impaired, being unable to see well at short range. She complained of great weakness, which has been becoming gradually worse for the past three months, and is not able to navigate without help, and is completely exhausted when attempting to make the least exertion. She complains of palpitation of the heart and a feeling as though she were going to faint. When examining the heart I found it very irregular at times, pulse-rate 145 and very compressible. Has had attacks of gastric crisis, in which she would vomit two or three days at a time, of an expulsive nature. She has had two of these attacks, but has vomited a number of times at intervals. Bowels have been quite loose, moving a number of times a day. This condition she thinks is becoming worse, and has been annoying her more or less for the last two months. The skin is very much pigmented and clammy. She also has considerable edema of her lower extremities. She is extremely nervous, unable to feed herself, and at times twitching and jerking almost as though she has an attack of chorea. She has not menstruated for the past eight months, and was very irregular for some time previous to that.

Operation.—February 2, A. M. Transverse incision; very vascular; many tortuous, large ves-

sels matted around and through the gland. I removed the right lobe of the gland and about one-half of the left. After securing all bleeding points in the field of operation the wound was drained thoroughly and partially closed. The patient was given an infusion of normal salt solution, 700 c. c., before awakening, and this was repeated by the rectum in eight hours. She only retained part of the enema, and again by the rectum in the following eight hours, which was promptly rejected. Morphine was administered hypodermically when necessary to allay restlessness; also atrophine, grain 1/100, was given hypodermically every eight hours for three doses following the operation. The patient's condition was favorable up until about the twentieth hour, when the condition became suddenly markedly worse, temparature gradually rising from the time of operation, also pulse-rate increasing, and her general condition becoming more and more serious until death, which occurred about the thirtieth hour following the operation. Three hours before death the pulse-rate was 200, respiration 60, temperature over 103°.

Case No. 2.—Mrs. V. V. C.; September 28, 1904; white, female, married; occupation, housewife. Family history negative, with the exception that her paternal grandmother died of supposedly tuberculosis. Past history negative, with the exception of having an attack of nervous prostration about three years ago which lasted several weeks. Menstruation period regular up until last June, and since that time she has not menstruated.

Present History.—About three years ago, while having a dress fitted, she noticed a slight swelling in the front part of her neck. This swelling increased very rapidly for the next three months; then she tried a goitre cure, which was an ointment and a tablet, and the tumor disappeared to a considerable extent. She took the full course of treatment, and while using this treatment she developed diarrhea, which has been more or less troublesome ever since. About this same time she noticed that the heart throbbed, and would jerk, as she expressed it. She claimed that when she first noticed the tumor that her heart beat fast and throbbed at times. She has lost weight gradually for the past three years, and this loss of weight has been more in the last year than the preceding two; also noticed that her eyes protruded about two years ago, which she attributed to vomiting, as she had frequent attacks. Suffered considerably with headache, always accompanied with vomiting spells. Headaches would last several hours and usually on the left side in the temporal region, and at this time the vomiting spells were worse than at any other. She has never been able to relieve these headaches with medicine, especially when the pain was on the left side. Sometimes medicine would relieve to a degree when the pain was located on the right side.

Complains of great shortness of breath for the past three months, and this condition is becoming more annoying all the time. Her eyes protrude very much, the left more than the right; cannot bear strong light, and the eyeball is sensitive to the touch.

Physical Examination. — Patient nervous and fidgety; expression that of a staring one; eyes protruding, sclera showing below the upper lid when looking straight ahead; some fullness and edema around the eyes; the eyelids do not follow the eyeball as they should; they respond slowly when the patient looks downwards; pulse 114, easily compressible, but her arteries seem to be in good condition. There is marked pulsation in vessels of the neck. In front on either side of the median line are two distinct growths—the one on the right side about the size of a split orange; on the left side about one-third the size of the former, and moves up and down when swallowing. Sensation to the touch is that of firm elastic mass, which pulsates to some extent, and a slight bruit can be felt on the left side. The right and larger lobe extends as high up as the thyroid cartilege and as low down as the sterno-clavicular articulation. With a stethoscope can be heard a stenotic blowing sound on the right side, which is possibly due to pressure on the large vessels of the neck. The same can be heard on the left side, but not so plainly. The heart is considerably dilated, and in placing the hand over the cardiac area can be felt a tumultuous movement, apparently missing beats from time to time. Placing the stethoscope over the cardiac area I find the heart to be very irregular, with a galloping motion, and this irregularity is very much increased by a little exertion.

Operation.—The transverse incision is made, the field of operation being a vascular one; numerous tortuous, dilated vessels around and through the gland; the capsule is split; the right lobe removed and the greater part of the left.

This patient made a very satisfactory recovery,

leaving the hospital on the twenty-eighth day after the operation, the maximum temperature being 102°, the maximum pulse-rate 120.

Case No. 3.—Mrs. C. M.; April 12, 1909; age 27, white, female, married; occupation, housewife. Family history negative, with the exception that the female members of the family are of a rather nervous character. Past history negative.

In regard to present trouble, she noticed first about three months ago a swelling in the front part of her neck, and has been quite nervous for the past few months; also complained that her heart and stomach have been giving her much trouble. After being annoyed with this condition for some time she called on her family physician, Dr. Snyder of Davenport, who recognized her condition and brought her here for treatment. Her facial expression was one of fright, her eyes protruding, and she was very nervous; had been unable to sleep and had quite a tremor of her hands, a general condition of unrest and nervousness. She complained of great weakness and shortness of breath upon the slightest exertion; tachycardia well marked; pulse rate 120. She complained constantly of a sensation of heat all over her body; perspired freely. This was more marked if she exercised or pretended to move about. She vomited frequently, and at times had a craving for certain foods, and one thing especially which she craved was raw tomatoes. Bowels quite loose, but no diarrhea.

Upon examining the neck I found a diffuse enlargement on both sides of the neck, the whole gland being involved. It had a firm feeling, and could detect a marked thrill, which was perceptible to both the touch and ear. There was a great increase in vascularity, and the veins pulsated and were much distended. The patient I kept under observation for several days, giving her sedatives, etc., but with no result.

Operation.—April 13, 1909. Made transverse incision down to capsule of the gland, which I opened longitudinally, and did the operation recommended by Ferguson, removing all the gland except a small bit at either of the outer four corners. The patient made an uneventful recovery, leaving the hospital on the tenth day. Maximum temperature, 101.6°; maximum pulse, 140.

Case No. 4.—G. M.; July 11, 1909; age 30, white, female, married; occupation, housewife. Family history negative, with the exception that she had a similar attack as she now has about nine years ago, which she recovered from without treatment, but that attack was not as severe as the present one, and lasted over a period of several months.

She noticed a few weeks ago that she was beginning to develop similar conditions as to what she had nine years ago and became quite irritable; has palpitation of the heart and became very easily irritated. This condition has gradually been growing worse up until the present time. She came to see me first on June 27, complaining of weakness, loss of appetite and being very nervous. On examination I found the thyroid gland enlarged, spread out over an unusually large area on both sides, extending down well below the sternoclavicular articulation; on both sides could elicit a thrill by the stethoscope, and the gland had an unusually firm feel. Exophthalmia was well marked, more so in the right eye than in the left. Tachycardia was not very great, except after exertion; pulse usually about 100; heart action full and strong; skin warm and clammy. I put her on medical treatment and rest, but her condition did not improve, her nervous symptoms gradually increasing, and she became very weak, unable to move about without a great effort; her hands shook, and she could not feed herself comfortably, and spent sleepless nights.

Operation.—July 12, 1909. Usual incision; removed the whole of the right lobe of thyroid except a small piece in upper outer angle and the inner third of left lobe. The gland was very large and very vascular. She made a very much slower recovery than any of the other exophthalmic cases, the weakness remaining with her for several weeks after leaving the hospital, and her eye symptoms, especially the exophthalmic condition, was the slowest in improving. She left the hospital the eleventh day after the operation, the maximum temperature being 102°, maximum pulse 110.

Case No. 5.—April 3, 1908; Mrs. M. McC., white, female, married, age 29. Family history negative. Has had three children, all living and in good health. Past history and physical examination negative with the exception of her goitre.

Present Trouble.—Began when she was about 18 years of age, and the growth has been very slow and has never given her any inconvenience, excepting it being unsightly and being annoying in case her dress collar should be a little snug, and

then it would give her a little choking sensation. The growth was rather hard to the feel and is located to the left of the trachea; is about the size of a large hen's egg, but more of a flattened contour.

Operation. — Transverse incision and growth very easily removed, it being a fibro-adenomatous condition of the gland. I regret very much that it was mislaid and no laboratory report was ever gotten. Patient made an uneventful recovery; remained in the hospital six days, the maximum temperature being 101.3°, maximum pulse 120.

Case No. 6.—Mrs. P. H.; September 25, 1908. This case was referred to me through the kindness of Dr. A. E. Johnson of Spokane. Age 53, white, female, married; occupation, housewife. Family history negative. Past history negative as regards the present trouble. Noticed swelling on right side of neck close to windpipe many years ago and thought nothing of it, it only giving her inconvenience when pressure was brought to bear upon it, and then it made her breathe hard, as she expressed it. In the past two years she says she has become more or less nervous and has worried about this lump, for it seems to press upon her windpipe and makes breathing difficult. This condition has been increasing in the past two years, and at present it is very difficult for her to do anything that causes the least exertion, for when doing so it causes a choking condition. She claims that on a number of occasions she has had severe choking attacks brought on by climbing the stairs rapidly or on exertion. There is a characteristic ring to her voice, which is noticeable in all cases where there is pressure on the windpipe, and in this case it is very pronounced. Upon examining her neck, found a firm symmetrical tumor close to the trachea in the right thyroid lobe, which moved up and down freely with deglutition.

Operation. — The usual incision: the tumor opened down and was peeled out very readily, which proved to be a tense cyst about the size of a large lemon. Patient made an uneventful recovery, leaving the hospital on the seventh day, maximum temperature being 100°, maximum pulse 88.

Case No. 7.—January 16, 1909; Mrs. L. J. D.; age 19, white, female, married; occupation, housewife. Family history negative. Past history of no consequence, except 10 weeks ago she gave birth to a child, born at term and normally, but ever since there has been a little flow of blood—not enough to keep her from getting about, but had always to wear a napkin. She thinks the amount would vary from a dram to half an ounce in the course of 24 hours. Gives history of having had two distinct attacks, appendicular in character, in the past 18 months, and on account of the bleeding and pain in her side she came to me for treatment, but had not up until this time considered the goitre. Abdominal palpitation revealed considerable tenderness in right side. Upon a vaginal examination, found that the uterus was slightly enlarged and blood trickling from the cervix; also could palpitate a cyst of the ovary about the size of a goose egg on the left side.

The woman being thin and neck rather long, I noticed the goitre, of which she had not made any mention, it being about the size of a small orange, symmetrical in character, but it had never given her any annoyance. She noticed it first about three years ago. The tumor did not hug the trachea, but occupied the outer portion of the gland on the left side. I advised her to have all done at one time—the curettement, laparotomy and the goitre—to which she and her husband consented.

Operation.—First, I curetted, finding a small bit of placental tissue in the uterus; then opened the abdomen, removed the cystic ovary and a long appendix containing fecal concretions, and then removed the goitre, using the usual incision. Upon cutting through the capsule of the gland I opened directly into the tumor, which was not truly cystic, but undergoing a cystic degeneration, the contents being fluid and a soft, coarse, pale, granular material, the whole time for the three operations being 55 minutes.

Patient made an uneventful recovery, leaving the hospital on the eleventh day. Maximum pulse, 116; maximum temperature, 100.4°.

Case No. 8.—July 28, 1909; Mrs. F. T.; age 31, colored, female, married; occupation, housewife. Family history negative. Past history of no consequence, except gives history of having had frequent attacks of pain in her back, which radiated into her right side, and very painful menstruations. She had a large swelling on the left side of her neck, extending quite deep down into the neck tissue, about the size of an orange; moved up and down freely on deglutition, but has never given her any trouble, excepting being un-

sightly; unable to wear a collar with comfort, patient's neck being quite short and thick. Upon vaginal examination, found a very long, small cervix, being about two and a half inches long and not much larger than a lead pencil; on the left side could feel a fluctuating mass, immovable, extending down to the vaginal canal between the right vaginal wall and the pelvis.

Operation.—Dilated the cervix, which was very hard to do on account of it being so small and rigid. I rather regret now that I did not do Pozzi's operation upon the cervix, as she is very anxious to have children, which I do not think possible with such a cervix for her ever to become pregnant. Then I opened the abdomen and removed a large interligamentous cyst which had dissected its way down into the vaginal cavity separating the vaginal wall from the pelvis. The cyst extended down at least half-way between the utero-vaginal connection and perineum, which made it difficult to dissect out. Then removed the goitre in the usual manner. Found the same condition existing as in case No. 7—a cystic degeneration containing a cloudy fluid, with a quantity of coarse granular material. Patient made a good recovery, being quite sick for the first three days following the operation, secreting a very small quantity of urine, but after that her recovery was uneventful, leaving the hospital on the sixteenth day. Maximum temperature, 101.8°; maximum pulse, 122.

Case No. 9.—July 13, 1909; M. L., aged 14 years, white, female, single; occupation, school girl. Past history of no consequence. Has been menstruating for the past two years. About one year ago noticed on the right side of her neck a fullness. This fullness has gradually been increasing in size. It gives her no trouble or annoyance, except that she is very sensitive and it being unsightly. The growth extends from the midline outward to the right for about three inches, and projects out about one inch. The gland was removed, it being parenchymatous in character. Patient made an uneventful recovery, leaving the hospital on the seventh day, maximum temperature being 101.4°, maximum pulse 108.

Case No. 10.—October, 1908; G. W., white, male, single; occupation, lineman. Family history negative. Past history negative. Came to see me suffering with a pronounced attack of typhoid fever; routine typhoid treatment being carried out, he had a very severe attack, temperature being the greater part of the time 104°, and on several occasions had chills, and temperature reached 106°. Suffered quite a great deal from abdominal tympanitis through the first two-thirds of his illness. Not able to leave the hospital for 46 days after his admittance. Was sick about one week before coming to the hospital. On the thirtieth day noticed quite a swelling in the right thyroid lobe, but it was not especially painful, but a little tender. Complained of considerable aching in that region of his neck. On examination, found considerable swelling in the right anterior part of his neck, the swelling being firm and distinct in outline. Cold applications were applied and were continued for the following three days. Swelling has not increased in size very much since this time, but it had become quite painful and tender. Cold applications were then discontinued. By this time I could make out a fluctuating mass, the skin being quite red and edematous over the tumor. I opened the gland under local anesthesia and found quite a quantity of pus (about one and a half ounces). The abscess cavity being drained, healed slowly and gave no further trouble. I am inclined to think that this was a pure typhoid infection, but, unfortunately, did not have an opportunity to make a culture at the time I opened the abscess.

GOITRE.

By Randolph Winslow, M.D., LL.D.

Physicians have been very tardy in recognizing the importance of the thyroid gland in the normal and pathological processes of the body. It is a small bilobed organ, with an intervening isthmus, situated on each side of the trachea and overlying the upper two or three rings of that tube. The gland normally weighs from one to two ounces. It has no duct, and consequently has an internal secretion, which is distributed to the system by means of the lymphatics or blood vessels, probably chiefly by the former. The blood supply is very extensive, being derived from the two superior and two inferior thyroid arteries, with sometimes an additional branch known as the arteria thyroidea ima, and with a corresponding venous circulation. The lymphatic network is also rich. The organ is surrounded with a connective-tissue capsule which dips into its interior, dividing it

into acini or lobules. The parenchyma of the thyroid gland consists of numerous closed vesicles, lined with a single layer of cuboidal epithelium, and containing a secretion known as colloid, which holds iodine in combination with albumen. The presence or absence of this thyro-iodine is supposed to be an important factor in the production of various aberrant conditions of the organism.

In close relation with the thyroid body are four small oval-shaped bodies known as the parathyroid glands, whose functions are not understood, but which exert an important influence in metabolism, as is shown by the fact that their absence or destruction is followed by a condition of tetany which often proves fatal. That the thyroid gland presides over important processes in the normal development of the body is shown by the lack of development of both mind and body when the gland is absent or so diseased that it is incapable of functionating properly. When a child is born with a deficient thyroid secretion he promptly presents a condition of stunted growth, defective intelligence or actual imbecility, coarse features, sparse growth of hair and other signs that form the complexus known as cretinism. If from surgical operation or disease the thyroid becomes incapable of supplying a secretion of sufficient quantity and proper character, a condition known as myxedema supervenes, which bears a very close resemblance to cretinism. These conditions are due to an absence or perversion of the internal thyroid secretion, and can be greatly benefited by the administration of thyroid extract or the dessicated powder of the thyroid gland.

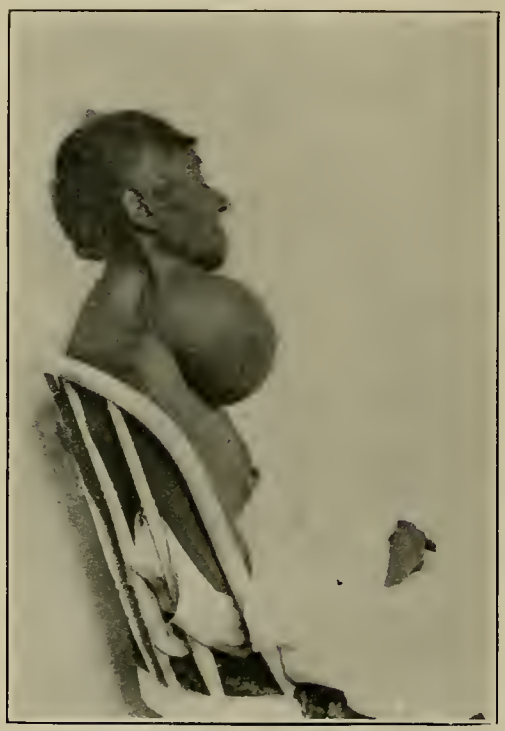
On the other hand, the thyroid gland may become too active and may furnish too much secretion to the system, and the condition of Graves' disease, or exophthalmic goitre, is produced, known by the greatly increased frequency of the heart's action or tachycardia, protrusion of the eyeballs or exophthalmos, and a marked enlargement of the thyroid gland, with perhaps bruit and thrill; other symptoms are tremor, sweating, nervousness and sometimes vomiting and diarrhea. This very interesting and very serious disease may run an acute course, with either spontaneous recovery or death, or it may be more chronic in its duration, and eventually prove fatal from secondary changes in the viscera. It is due to too great an absorption of thyroid fluid, and may be cured or alleviated by any method of treatment that diminishes this production and absorption of thyroid secretion. This may at times be accomplished by the administration of drugs or by sanitary or dietetic measures, but is best secured through a surgical operation on the gland itself or by the ligation of its blood vessels.

The thyroid gland is subject to the various injuries and diseases that occur in other organs, such as wounds, inflammatory processes, abscess, syphilis and tuberculosis, but these are rare and do not differ materially from similar conditions elsewhere either in their symptomatology or treatment. The importance of this organ from a surgical standpoint is due to its tendency to undergo tumor formation. An enlargement of the thyroid is known as a goitre, bronchocele or struma, of which there are several varieties. When the whole gland is enlarged it is called a diffuse goitre; when, as is more frequently the case, only isolated portions are involved the term modular goitre is applied to it. When the thyroid gland is uniformly enlarged by an increase of all its histological elements, but especially of its epithelial cells, it is called a simple or parenchymatous goitre. If the vesicles are markedly distended with secretion, the swelling is called a colloid goitre. When one or more vesicles become filled with fluid so as to form a distinct cyst or cysts, the condition is known as cystic goitre. An adenomatous goitre is a condition where the glandular elements are aggregated into distinct tumor masses, forming usually hard, firm nodules surrounded by a connective-tissue capsule. Sometimes the interlobular areolar tissue becomes increased, forming a fibrous goitre, or the blood vessels may be in excess, forming a vascular goitre. These different forms are not often found as distinct varieties, but are usually associated to a greater or less extent. I have already briefly mentioned that peculiar malady known as Graves' disease, Basedow's disease, or exophthalmic goitre, which is a constitutional disease due to excessive secretion and absorption from an overacting thyroid gland.

The thyroid is also subject to malignant degeneration of both the sarcomatous and carcinomatous forms.

The object of this paper is to discuss briefly and simply the subject of goitre in its various manifestations. This distressing and hideous malforma-

tion is found in all parts of the world, but is much more frequent in some countries than in others, and in certain localities of a country than in other parts of the same country. It occurs with especial frequency in Switzerland, the Austrian Tyrol, the south of France, Italy and India. Whilst it does not occur so frequently in the United States, it is by no means infrequent. It occurs sporadically in all parts of Maryland, but is endemic in the mountainous portions of the State. Endemic goitre is doubtless due to the drinking water which is derived from certain geological strata of rocks, but this will not explain the origin of most of the sporadic cases that occur in all parts of the



known world. It may be a congenital condition, and heredity certainly plays some part in its production, as it frequently affects several generations of the same family. Females are much more liable to the disease than are males, and it is usually first noticed before 30 years of age—often, indeed, about the period of puberty. It may not occur until after 40 years of age, in which case one must think of cancer. The disfigurement of goitre is always great when the growth has reached a considerable size, and, as it usually affects women, it is a source of great annoyance and distress. One of my earliest recollections is of an excellent lady with a huge cystic goitre, who might easily have been cured by an appropriate operation. A goitre may attain such proportions that it overhangs the front of the chest (Fig. 1), or it may dip behind the sternum and pass into the anterior mediastinum and cause pressure on the vessels and nerves of the thorax, causing cyanosis and dyspnea. At times the intrathoracic growth ascends during expiration to disappear again in inspiration. This is known as "goitre plongeant" by the French. Even when the growth remains limited to the neck, it may cause pressure on the trachea or displacement of this tube to such an extent that respiration is interfered with, or the vessels and nerves may be so compressed that cyanosis, dyspnea, dysphagia, cough and alteration of the voice occurs. Goitre is sometimes attended with symptoms of myxedema, from the loss of secreting structure or from the pressure of neoplastic formations on the normal gland structure. More commonly, however, there are produced symptoms of resembling Graves' disease from overdevelopment of the glandular tissue, with an exaggeration of the thyroid secretion. In fact, there is a very slight step between some of the ordinary forms of goitre, with nervous symptoms and increased frequency of the heart's action, and Graves' disease.

The whole or any part of the thyroid may be the seat of goitre; frequently one side is affected more than the other, and it is usually the right lobe that is most involved. There is a great tendency for the growth to rotate toward the middle line and to form a rounded tumor overlying the trachea and attached to it. In consequence of this, the mass moves up and down during the respiratory acts, as well as in swallowing and coughing, and this is a valuable diagnostic sign in the differentiation of goitre from other neoplasms of the neck. When the struma is extensive it will extend under the sterno-cleido-mastoid muscles, pushing them outwardly, and in some cases it may extend into the posterior triangles of the neck. Accessory thyroid growths may be found in unusual and unexpected situations, and may then be difficult to diagnosticate before removal.

One can scarcely mistake a well-formed goitre for any other condition, but the different varieties present some diversity of symptoms. A parenchymatous or colloid goitre is usually uniformly enlarged, smooth, not very hard, but may cause dyspnea by pressure on the trachea. An adenomatous goitre is irregular in shape, with isolated hard masses or nodules imbedded in its sub-

stance. A cystic goitre may attain a large size, forming an elastic, resilient tumor, with a sense of fluctuation. When a rounded mass can be seen and felt in the thyroid gland it indicates that an encapsulated growth, solid or cystic, is present, which frequently can be removed without sacrificing the gland.

The symptoms of exophthalmic goitre are well known, but it is important to recognize the condition before the bulging of the eyes and marked swelling of the thyroid occur. There are many cases of rapid pulse and nervousness that are due to too much thyroid absorption long before there is any exophthalmos or visible swelling of the gland. Malignant disease of the thyroid gland occurs in a considerable number of cases, and a simple goitre may become a malignant one. A rapidly growing and irregular thyroid gland occurring after 35 or 40 years of age is likely to be malignant. When its malignancy is sufficiently apparent to permit a ready diagnosis the time for a successful operation has already passed; hence the importance of dealing with goitre in a timely manner. The surgeons of this country have been slow to treat tumors of the thyroid body by removal. In 1883, when I was a student in Vienna, I saw a number of thyroid excisions by Billroth and his assistants, and though their methods were crude in comparison with those of Kocher, C. H. Mayo and others at this time, yet they were far in advance of us in the treatment of these conditions at that time. I did not see another operation for goitre until I began to operate myself in 1900. At the present time the technique of partial thyroidectomy and of other operations on the thyroid gland has been perfected to such a degree that the mortality in the case of the ordinary forms of goitre is very small, and the permanent results, both of a cosmetic and of a curative character, are unusually satisfactory. I do not wish to be understood that every case of enlargement of the thyroid gland should be treated by operative means. Some cases, especially those occurring in girls about the period of puberty, subside spontaneously; others are amenable to medical and hygienic measures, and some remain quiescent or give but little distress to the patient. The vast majority of cases, however, are progressive, and sooner or later become not only sources of disfigurement, but of danger from pressure on the trachea and vessels, as well as from changes in the gland itself, either causing too much thyroid secretion, with symptoms of Graves' disease, or too little secretion, with symptoms of myxedema. Again, malignant degeneration occurs in previously non-malignant goitres in a considerable percentage of cases, and the only hope of a radical cure is when an excision is done at such an early stage that the malignant action cannot be recognized previous to removal.

Exophthalmic goitre is, of course, a much more serious condition than that of simple thyroid overgrowths, and the mortality following operation is greater than in those cases, yet it is not excessive. The mortality is due not so much to the operative procedures as to the degenerations in the heart, liver, spleen and other organs, the result of permitting the absorption of toxic secretions for a long period. All forms of goitre, except the malignant, are susceptible of cure or of marked alleviation by operation at the hands of a competent surgeon. Whilst the dangers are manifold, they may be avoided by the exercise of care and skill. Hemorrhage is likely to be troublesome, and possibly dangerous, unless the vessels are carefully isolated and clamped before they are cut. Injury to the recurrent laryngeal nerves and to the parathyroid glands can be avoided by keeping within the connective-tissue capsule of the gland. Sepsis should not occur if an aseptic technique has been observed. A very serious peril is acute thyroidism, which may come on almost immediately or in from 24 to 48 hours, due to active absorption of thyroid secretion, possibly forced into the circulation by undue handling of the gland. In this alarming and often fatal complication the patient becomes wildly delirious, with a high temperature, rapid and thready pulse, and often vomiting and sweating; in fact, with the symptoms of acute Graves' disease. Death usually closes the scene in from one to three days. We attempt to prevent this condition by avoidance of rough handling of the gland, by covering raw surfaces with the capsule and by establishing drainage for from 24 to 48 hours. In former days tetany frequently followed the removal of the thyroid gland, but the cause was not understood. We now know that it is the result of removal of the parathyroid glandules, which are in close proximity to the thyroid. This serious accident can usually be avoided by keeping within the capsule, as has been taught us

by Charles H. Mayo. Injury to the recurrent laryngeal nerve is followed by paralysis of the vocal cord of the same side, and whilst it is an unfortunate occurrence, it does not, as a rule, cause much annoyance. This may also be avoided by keeping within the capsule. Operations on the thyroid gland are best performed with the patient in an almost sitting position and with a roll under the neck to make the field of operation more prominent, as in this posture there is an unimpeded return of the venous blood to the heart, with less congestion and hemorrhage during the operation. The question of an anesthetic is a mooted one. Professor Kocher, who has the largest experience of any man in the world, prefers local anesthesia with eocaine or novacaine, but in these cases the operation is by no means painless, as I know from observation at the Kocher clinic at Bern, Switzerland, as well as from my own personal experience. The patients can, however, stand the operation, and the method posseses advantages. I have usually operated under local anesthesia, with the addition of the use of morphia and scopolamin hypodermically. Dr. Charles H. Mayo has proven conclusively that general anesthesia is not especially perilous in these cases, and in the vast majority of his operations the patients are under the influence of ether. I know of no condition, however, in which it is more important to have the anesthetic administered by a skilled anesthetist than in cases of exophthalmic goitre, or, as it is sometimes called, hyperthyroidism.

Several operations are applicable to the cure or relief of goitre, and the one selected will depend upon the particular form of thyroid disease present. In diffuse parenchymatous or colloid goitre a partial thyroidectomy should be done, as is the case also in most cases of exophthalmic goitre, one lobe and the isthmus being removed, with sometimes a part of the remaining lobe. A complete removal of the thyroid gland should never be performed, except in the case of malignant disease. When it is necessary to excise the whole gland, the patient must be fed with thyroid extract or powder, to forestall a fatal cocchexia strumipriva. In many cases of Graves' disease it will be best to ligate the two superior thyroid vessels as a preliminary operation, and subsequently do a partial thyroidectomy. In some cases a cure results from the ligation of the vessels without any further procedure. As the symptoms of Graves' disease are due to too much thyroid absorption, do not increase the poisoning by giving thyroid preparations to the patient. When there are nodular masses in the thyroid, either solid or cystic, they may be enucleated entire, leaving the thyroid structure practically intact. A prominent rounded projection usually means an encapsulated cyst, which can be shelled out easily and safely. As a general proposition most forms of goitre are best treated by a partial thyroidectomy after a reasonable trial of hygienic, dietetic and medicinal therapeutics. Long delay should be discouraged on account of the liability of injurious effects from pressure on important structures, as well as from alterations in the gland itself, either of a malignant character or from a change in the nature and amount of the internal secretion, which may become excessive and cause symptoms of hyperthyroidism, or deficient, with hypothyroidism or myxedema.

(To be continued.)

REPORT OF CASES IN WHICH ABDOMINAL PAIN WAS THE ONLY SYMPTOM.

By Arthur M. Shipley, M.D.

These cases are reported not because they are unusual, but because they are good examples of a surgical condition which is often neglected. Pain in the abdomen is one of the commonest of the symptoms of human ills. The causes of this same pain are legion. Some of these conditions producing abdominal pain require surgical interference and many do not. The following cases are interesting because pain in each case was the only symptom, and because in several of them diagnoses far removed from the correct one had been made:

Case I. This patient was a young man whom I saw in the Emergency Hospital at Easton, Md., in consultation with Dr. Stevens. He had been complaining of attacks of abdominal pain. He was thin, and abdominal palpation was thereby rendered easy. His projecting spinal column, with the aorta in front of it, felt very like a pulsating abdominal tumor. Careful examination threw out the possibility of aneurysm. The abdominal wall was not rigid in any portion, and no tenderness could be brought out by ordinary palpation. He was not tender over the appendix

region to either light or deep palpation. The pain had been chiefly felt in the center of the abdomen around the umbilicus, and was intermittent in character, with no history of temperature or pulse disturbance. While ordinary palpation revealed nothing over McBurney's point, pain could be brought out as follows: If the palpating fingers, using moderate pressure, were gradually pulled along the lower right abdomen from the central line out toward the crest of the ilium, a resistance could be felt as if tension were being made against resistance, and this manipulation always gave pain. If the fingers were moved still farther toward the ilium and the pressure lessened, something could be felt slipping under the fingers back toward the center of the abdomen, and this was followed by cessation of pain. This pain was similar in character to the attacks of pain from which he had suffered. Rectal examination was negative and there had been no symptoms of obstruction.

Operation was advised and accepted. A right rectus incision was made, and examination of the abdomen showed a chronic appendix, rather long, pulled over the top of the cecum and adherent throughout half its length to the mesentery of the small gut near the intestine. It was the middle portion of the appendix that was attached, the distal third and a small portion near its attachment to the cecum being free.

Case II. This patient was a woman who had borne children and had been operated on several years previously for some pelvic condition requiring drainage. For some time after operation she was comfortable. Pain, however, began to be noticed, and this gradually became more and more severe, and was constant. This pain was felt in the middle abdomen above the wound of operation, and was felt also in the back. She described it as a sensation resembling pulling. She had no ventral hernia. The pain finally became unbearable and she sought surgical help. On opening her abdominal cavity the uterus was almost entirely covered throughout its peritoneal surface by the omentum, which was tightly adherent to the back, sides and front. It reached almost to the bottom of the cul-de-sac of Douglas. When the adherent omentum was dissected away the entire peritoneal surface of the uterus was raw and bleeding, and as future adhesions were feared, and the woman had reached her menopause, hysterectomy was performed. The patient made a good recovery and has had absolutely no recurrence of her pain.

Case III. This patient is a colored woman who was operated on four years ago for large pus tubes. She was drained, and a ventral hernia developed at the site of the drain. Some time ago she began to have abdominal pain, and this has increased in severity. It is worse in the evening, and is not felt when she is in the reclining position. There is a large ventral hernia which disappears when she is lying down and protrudes when she is standing. Operation was advised and refused. She was told to have a support made in order to prevent the protrusion of her hernia while she is on her feet. This was done, and the abdominal pain and backache have disappeared.

Case IV. This patient was a white man, 69 years old, who several months before had his leg broken. During his necessary confinement to bed his tissues became very flabby, and when he started to get about on his feet he began to have a great deal of abdominal pain. He had had double inguinal hernia for years, which he had always controlled with a truss. Now, however, the rings, especially on the right side, became so open that his truss did not help him. He could not keep his right hernia reduced, and his pain increased in severity until he finally decided to have his hernias cured.

At operation, on the left side, there was an ordinary large, acquired, oblique inguinal hernia. On the right side, however, the sac contained large intestine and omentum tightly adherent to the hernial sac, which descended well down into the scrotum. There was no strangulation and there had been no symptoms of obstruction. The gut and omentum were freed from the sac and replaced in the abdomen, the sac was excised and the hernial opening closed. He made an uneventful recovery, with complete relief from pain.

Case V. This patient was a young man who had suffered from repeated attacks of pain in the right side of his abdomen. A diagnosis of appendicitis was made and he was sent to the University Hospital for operation. On examination neither pain nor tenderness on the right side could be made out, nor was there any rigidity. There was no history of temperature disturbance during these spasms of pain, which were becoming more frequent.

At operation the appendix was slightly congested and was removed, but the real cause of his

pain was a band of adhesion about three inches broad which pulled the cecum down and fastened it closely and firmly to the side of the pelvis. This was separated, and recovery from the operation was followed by relief from pain.

In all five of these cases pain was the only symptom—pain in the abdomen—and in four of them the pain was referred to the center of the abdomen in the region of the umbilicus. In none of these cases were there any symptoms of obstruction, and at operation no interference with the lumen of the gut was found. In all of them the pain was due to tension on either the omentum or mesentery. They had been treated for different conditions for varying periods of time. The woman whose omentum was adherent to the uterus had been treated for uterine displacement with various forms of pessaries without relief.

Case IV shows the uselessness of a truss in large incarcerated hernias. Indeed, the truss may do positive harm by making pressure upon unreduced gut or omentum in the sac.

Every operator sees this class of patients, where pain in the abdomen is the only symptom—pain that persists in spite of treatment. In these cases very often no objective symptom may be present—muscle spasm, tenderness, etc.—and the absence of symptoms leads to various diagnoses, such as constipation, enteroptosis, neurasthenia, etc. Usually these cases are seen by the surgeon only after all other means have failed and at a time when the family of the patient, as well as the physician himself, begins to look on him as a neurasthenic. The results are extremely satisfactory. The operative procedures are usually simple, and the complete relief from pain on the part of the patient is very gratifying both to the surgeon and to himself.

THE COURSE OF OPERATIVE SURGERY IN THE UNIVERSITY OF MARYLAND.

By Nathan Winslow, M.D.

Since my student days there has been a marked improvement in the method of teaching operative surgery in the University of Maryland. At that time, session of 1900, the course extended only over a short period, and the students as a class were privileged to witness some few operations by the demonstrator from the benches of anatomical hall. Naturally only the merest insight into the mysteries of operative work could be gleaned by this method. The course was better than nothing at all, but not much better. Anybody can easily recognize the folly of trying to teach students operative technique in this novel manner. Today, and, indeed, for the past five or six years, better measures prevail for the imparting of this branch of surgery to the student. Instead of endeavoring to teach the class as a body, with the members perched high upon the benches, the class is divided into sections. Until this year there were six sections, each of which received about three months' instruction upon the simpler and major operations in the dissecting-room on the cadaver. This method of handling the class was found not to the best advantage, as there was too little time for the amount of ground to be covered. So this year the class, third year, was divided into three sections, and the course is to run through the year. Professor Martin has been made head of the department, with Professor Spruill and Dr. Nathan Winslow as his assistants. At this early period there is improvement in the teaching, and the students, not being so rushed, manifest more interest in their work. We do not claim that this method of teaching surgery is ideal, but it certainly is far in advance of the method employed in, and previous to, the session of 1900. It also supplies to those men who are so unfortunate as not to be internes some experience with the use of the knife and the handling of tissues. During actual operations these men are so far removed from the seat of operative interference that they see little of what is going on; consequently when graduated are at a disadvantage as to how to proceed even in the simplest operations. By this course we attempt, and, in fact, do supply to a large extent the loss of actual experience on the living. In the near future we hope to still further increase the efficiency of this department by instituting work upon the animal. This, though not taking the place of operations upon the living, will make the student acquainted with the handling of live tissues and the checking of hemorrhage, and increase his resourcefulness in meeting emergencies. Herewith appended is an outline of the course as at present constituted:

Part I.

(*a*) Description of instruments and accessories, including sutures and methods of application.

(*b*) Instruction as to the use of the knife;

how to handle it in making wounds, and the proper method of dissection in the ordinary operative procedure.

(*c*) Describe methods of arresting bleeding. Give instruction in intravenous infusion, venesection.

PART II.

Ligature of Arteries.

(*a*) General instruction.

(*b*) Ligature of arteries of upper limbs, including ligation of radial, ulnar, brachial at bend of elbow, brachial in middle of the arm, axillary; ligature of arteries of head and neck, including ligation of subclavian, innominate, common carotid, lingual, middle meningeal; ligature of arteries of lower limbs, including femoral, anterior and posterior tibial.

PART III.

Operations Upon Nerves.

One or two demonstrations, including excision of some of the nerves of the face.

PART IV.

Operations Upon Bones and Joints.

(*a*) Osteotomy.

(*b*) Operations for treatment of ununited fractures.

(*c*) Excision of joints, including wrist, elbow, shoulder, ankle, knee and hip.

PART V.

Amputations.

(*a*) Finger and toe amputations.

(*b*) Classical amputations about the feet—Hey's, Lisfranc's, Chopart's, Syme's, Pirogoff's.

(*c*) Amputation of leg, thigh, disarticulation at hip, forearm, arm, and disarticulation at shoulder.

PART VI.

Operations on the Head.

(*a*) Including operations upon the skull, trephining, and Gasserian ganglion excision.

PART VII.

Operations on the Neck.

(*a*) Tracheotomy and laryngotomy.

(*b*) Excision of the thyroid, of the tongue.

(*c*) Operations on the esophagus.

PART VIII.

Operations on the Thorax and Breast.

(*a*) Excision of the rib for empyema.

(*b*) Radical breast amputation.

PART IX.

Operations on the Abdomen.

1. Operations on the stomach:
   - (*a*) Gastrotomy.
   - (*b*) Gastrostomy.
   - (*c*) Gastroenterotomy.
   - (*d*) Pylorectomy.
   - (*e*) Pyloroplasty.
2. Operations on the gall-bladder:
   - (*a*) Cholecystotomy.
   - (*b*) Cholecystectomy.
3. Intestinal resection and anastomosis:
   - (*a*) Give end-to-end anastomosis both by mechanical device and suture method. Describe in detail the methods of suture used in intestinal work.
   - (*b*) Colostomy.
   - (*c*) Resection of cecum.
4. Appendectomy.
5. Hernia, inguinal, femoral and umbilical.
6. Operations on kidney.

PART X.

Operations on Bladder.

(*a*) Suprapubic cystotomy.

A cursory glance at this schedule will show that the ground covered is considerable. In order to insure that the students get the best that is in the course, they do as far as possible the actual operative work under the supervision of the instructor. The work is thorough, and we feel certain the knowledge thus obtained will prove of inestimable value to the student in his future work.

THE PROFESSORS OF SURGERY IN THE UNIVERSITY OF MARYLAND.

By RANDOLPH WINSLOW, M.D.

No. 6.—LOUIS MCLANE TIFFANY, M.A., M.D.

One of the most distinguished men who has held the surgical chair in the University of Maryland is Dr. Louis McLane Tiffany. Upon the resignation of Professor Johnston in 1881, Dr. Tiffany, who had previously been professor of operative surgery, became professor of surgery, and continued in this position until 1902—a period of 21 years—when he resigned and retired to a well-earned leisure. Dr. Tiffany was born in Baltimore October 10, 1844. His collegiate education

was obtained at the University of Cambridge, in England, where he received the degree of B.A. in 1866, and some years thereafter the degree of M.A. was conferred upon him by the same institution. He graduated from the University of Maryland in 1868. During the period of his pupilage in medicine he was an office student of Prof. Nathan R. Smith, and doubtless to this fact is largely due his aptitude for surgical work. Shortly after graduating he became resident physician at Bayview Asylum, and subsequently for a number of years was visiting physician to the same institution. The year after graduation he became demonstrator of anatomy in the university, and in 1874 was made professor of operative surgery, succeeding Dr. Alan P. Smith, who had held that chair for one year. Dr. Tiffany was a surgeon of wide repute and national reputation. He was a conservative operator, and paid close, personal attention to his patients, both previous and subsequent to operation. He performed many remarkable operations with great success, and for many years dominated surgical thought, as well as surgical practice, in this city. Amongst his more important surgical achievements was temporary depression of both upper jaws for the removal of a large naso-pharyngeal polypus in the case of a man, who recovered from the operation. He repeated this operation on another individual at a later period, which also terminated successfully. He performed the first nephro-lithotomy in the United States in 1885, removing successfully a large calculus from the kidney. He also achieved special distinction by his operations for the removal of the Gasserian ganglion for inveterate facial neuralgia. He removed successfully the spleen for malarial hypertrophy; and, indeed, his surgical activities were very varied and extensive. He was an earnest teacher, impressing with force his convictions upon his students. Whilst not an orator, his lectures were impressive and instructive to his students, who ever thereafter were able to bear in mind the important lessons that he strove to impress upon them. He contributed frequent articles to the various medical journals of the country, and wrote the article upon the "Surgical Diseases of the Jaws and Teeth" in the third volume of Dennis' "System of Surgery," published in 1895, and also the chapter upon "Cranial Surgery" in the first volume of the "International Textbook of Surgery," published in 1899. He was a member of the American Surgical Association and of the Southern Surgical and Gynecological Association, and was president of both associations during the same year. As a young man Dr. Tiffany was a noted athlete, and was the recipient of honors in running at Cambridge University, England, where he made a world's record. He was also a good player of both baseball and cricket, and to his participation in athletic exercises doubtless was due that strength of body, as well as, perhaps, to some extent, the virility of mind, which were his characteristics. In the words of Professor Cordell, "As a surgeon he was studious, industrious, patient, conservative, but at the same time broad, original and self-confident. He possessed in a large degree that self-confidence which comes from meeting and overcoming difficulties." Since 1902 Dr. Tiffany has practically retired from professional work of all kinds, and spends his summers upon his estate on the Eastern Shore of Virginia, whilst his winters are usually spent in Baltimore and Florida. He has earned a well-merited rest from professional labors, and we hope that he may live long to enjoy his dignified and scholarly repose.

ITEMS

Dr. James Cartwright Wyncoop, class of 1892, practiced medicine several years in Virginia before locating permanently in Washington, D. C. He is a native of Virginia, and was born in Loudoun county. He is a son of Philip Henry Wyncoop and Catherine Corr, his wife, and is of American descent.

His earlier education was acquired in public schools of his State and his higher education in the University of Virginia. He was educated in medicine at the University of Maryland Medical Department, which he entered in 1890, and was graduated in 1892. Before entering upon his medical course he taught school for three years in Virginia. In 1897 he took a course in the New York Postgraduate Hospital. Dr. Wyncoop began his professional career at Hillsboro, Va., in 1893 and removed to Washington in 1901. He is a general practitioner. He is a member of the Virginia State Medical Society and the District of Columbia Medical Association. On the 13th of October, 1898, Dr. Wyncoop married Bessie Herbert de Butts, by whom he has three chil-

dren—James Cartwright, Nannie Dulany and Katherine Wyncoop.

Dr. Henry J. Berkley was born at Baltimore July 17, 1860. He was graduated from the University of Maryland Medical Department with the class of 1881. After graduation he was demonstrator of anatomy, College of Physicians and Surgeons, Baltimore. He then continued his studies abroad. He commenced practice at Baltimore in 1888. From 1888 to 1890 he was chief of the neurological clinic, University of Maryland. He then became connected with the Johns Hopkins with the position of associate in neuropathology. From 1893 to 1898 he held the position of clinical lecturer in psychiatry, Johns Hopkins University. In 1898 he was advanced to the position of clinical professor of psychiatry, Johns Hopkins University, which chair he holds at present. He is a visiting physician to Bayview Hospital and resides at 1305 Park avenue, Baltimore. For many years Dr. Berkley has been a leading alienist of Baltimore and is a decided credit to his alma mater.

Dr. John I. Pennington, class of 1869, of Baltimore, Md., a physician of more than 40 years of rich experience in general practice, ex-president of the Baltimore Medical and Surgical Association and a man of high reputation both in professional and social life, is a native of Kent county, Md. He was born December 10, 1842. He is a son of the late James H. and Martha J. Pryor Pennington and a descendant of American ancestors. His grandfather was an officer of the American army in the second war with Great Britain.

Dr. Pennington's early education was obtained in public schools and his professional in the medical department of the University of Maryland, whence he graduated with the degree of M.D. with the class of 1869. After graduation he did special work in the throat department of the Presbyterian Eye, Ear, Nose and Throat Hospital. The scene of his professional life has been Baltimore, where, in connection with general practice, he has been identified with several prominent institutions of the city. He is a member of the American Medical Association, the Medical and Chirurgical Faculty of Maryland, which he joined in 1876; a member of the defunct Baltimore Medical and Surgical Association, of which he was at one time president, and of the Baltimore Medical Association.

On March 21, 1876, Dr. Pennington married Miss Virginia Marston, who is now dead.

Dr. Pennington has always evinced a lively interest in the affairs of the University of Maryland and has remained identified with that institution by joining the Medical Alumni Association.

Dr. Charles Frederick Bevans, class of 1871, is another graduate of the medical department of the University of Maryland who has made a name for himself in his chosen profession. He was born June 14, 1850. He was educated at the University of Virginia and the University of Maryland, from the latter of which he was graduated with the degree of M.D. in 1871. He was attending physician Baltimore General Dispensary, 1876-1878; attending physician Baltimore Special Dispensary (1872) until its close; demonstrator of anatomy College of Physicians and Surgeons, Baltimore, 1872-1876; lecturer on osteology College of Physicians and Surgeons, 1876-1888; professor of surgery College of Physicians and Surgeons, 1888 to date; professor of anatomy Baltimore College of Dental Surgery, 1876-1878; attending physician Nursery and Child's Hospital, 1878; visiting surgeon Bayview Hospital, 1888; assistant surgeon Seventh Maryland Regiment of Infantry, M. N. G. He resides at 807 Cathedral street.

Dr. Hampson Hubert Biedler of Baltimore, Md., is a native of Virginia. He was born at Page View, Page county, August 26, 1854, and is a son of Ambrose M. and Sarah A. Keyser Biedler. After attending Hawksville Academy, Virginia, he entered the New Market (Va.) Polytechnic Institute, where he completed a three-year course. For a short time he taught school and then entered upon the study of medicine under the office preceptorship of Drs. Miller and Brumbach in Luray, Page county, Va. He completed his professional preparation in the medical department of the University of Maryland, whence he was graduated February 29, 1876. During the closing year of his course he was a resident student at the University Hospital. Immediately following his graduation, he took a six-month practical course in pathology and microscopy in the office of the microscopist of the Army Medical Museum, Washington, D. C. He

entered upon practice in Woodville, Rappahannock county, Va., but after six years' residence migrated to Baltimore. The following year he was called to the chair of diseases of women Baltimore Medical College, and shortly afterward was elected to the chair of surgery. Since the incorporation of Baltimore University he has been its secretary, and in 1897-1898 filled the chair of principles and practice of surgery and was dean of the faculty. He has written voluminously on medical and surgical topics. He is a member of the Medical and Chirurgical Faculty, the American Medical Association, and was president of the now extinct Baltimore Medical and Surgical Association.

The annual meeting of the adjunct faculty of the University of Maryland Medical Department was held Tuesday, January 25, 1910, in Davidge Hall, Lombard and Greene streets, at 8.30 P. M. Matters of importance were discussed, among which was the decision to give a smoker to the senior medical class February 26, 1910. The following officers were elected for the ensuing year: President, Dr. Irving J. Spear: vice-president, Dr. Compton Riely; secretary-treasurer, Dr. J. Holmes Smith, Jr.

The retiring officers were: President, Dr. J. H. Holland; secretary-treasurer, Dr. Roscoe Metzel.

Drs. Nathan Winslow and W. D. Scott, with the president as an ex-officio member, were appointed a committee to make arrangements for the above-mentioned smoker.

The last regular meeting of the University of Maryland Medical Association was held in the amphithertre of the University Hospital Tuesday, January 18, 1910, at 8.30 P. M., with Dr. John T. O'Mara, the president, in the chair. The program was as follows: (1) Criminal Insanity, Dr. M. Bruns; (2) A Few Remarks on the Surgery of the Kidney and Ureter, Dr. Frank Martin.

The annual meeting of the Anne Arundel County Medical Society was held at Carvel Hall, Annapolis, Tuesday, January 11, 1910, at 1 P. M. The following of our alumni read papers: Goitre, Dr. Randolph Winslow; Conjunctivitis: Its Causes, Prevention and Cure, Dr. Herbert Harlan; Opsonins and the Opsonic Index, Dr. William Royal Stokes. Immediately preceding the meeting a luncheon was held, at which there were more than 50 present, many of whom were visitors from Baltimore. The affair was a thoroughly enjoyable occasion, and much good-will was manifest. The success of the meeting was due to the indefatigable endeavors of Dr. Louis B. Henkel, Jr., an alumnus of this university. He certainly deserves credit for the variety and the excellence of the papers presented.

The section on Clinical Medicine and Surgery, Baltimore City Medical Society, held its last meeting Friday, January 7, 1910. Dr. Frank Martin read a paper on "Remarks on Renal and Ureteral Surgery."

Dr. N. M. Owensby, at the meeting of the section on Neurology and Psychiatry, Friday, January 14, 1910, read a paper entitled "Functional Neuroses of Childhood."

Dr. L. Kolb, class of 1908, Public Health and Marine-Hospital Service, was granted a three days' leave of absence from December 24, 1909.

Dr. W. L. Lewis, class of 1892, acted as chairman of the meeting held at Kensington, Md., January 21, 1910, under the auspices of the Social Service League of Montgomery County in the interest of public health. Dr. O. M. Linthicum, class of 1890, president of the Montgomery County Medical Society, also was among those present.

In a recent issue of *Musical America*, Dr. John C. Hemmeter, professor of physiology in the University of Maryland, says that it is time that the American public should insist upon the performance of operas in its own language. He states that it is the only nation which permits itself to be sung to continuously in foreign languages. It is not because we have not sufficient numbers of trained American singers of sufficiently high artistic ability to sing upon any operatic stage in the country. We have plenty such. There are a great many American singers on the British and German operatic stages, and it is no exaggeration to state that a complete opera company, embodying the highest achievements of the musical stage, could be equipped entirely out of Americans—choruses, soloists and even the director, included.

Dr. Joshua Hering, class of 1855, has qualified for the fourth time as Comptroller of the State of

Maryland. Dr. Hering at the recent academic exercises was given the honary degree of LL.D. by his alma mater as a testimonial of the high regard she had for him.

Dr. J. Whitridge Williams has resigned as head of the Hopkins Dispensary.

Dr. C. H. Medders has returned from St. Augustine and Palm Beach, Fla.

Miss Bertha Wilson has resigned as superintendent of the University Hospital. She will be succeeded by Miss Alice Frances Bell, a graduate of the University Hospital Training School for Nurses.

Dr. William R. Rogers, class of 1901, is located at Bristol, Va., where he is engaged in both medical and surgical work. He has succeeded in building up quite a large and lucrative practice. He was recently in Baltimore, and visited his friends at the University Hospital.

Dr. Guy Asper of Chambersburg, Pa., paid the university a visit recently.

Dr. Joshua W. Hering is a member of the board of directors of Springfield State Asylum.

The board of directors of the Springfield State Asylum in their biennial report to the Governor say: "For the efficient management and excellent condition of the hospital credit is due in the first place to the superintendent, Dr. J. Clement Clark, whose efforts are well supported by the medical staff."

The managers of the Baltimore General Dispensary, 651 West Lexington street, have elected Dr. Edward E. McKenzie a physician to the institution.

Among our alumni who attended the recent meeting of the Anne Arundel County Medical Society were the following: Drs. Randolph Winslow, T. A. Ashby, Nathan Winslow, J. D. Reeder, R. P. Bay, A. M. Shipley, John R. Winslow, Frank J. Kirby, C. R. Winterson, H. B. Gannt, J. L. Bowen, J. O. Purvis, J. J. Murphy, W. H. Hopkins, W. Clement Claude and Louis B. Henkel, Jr.

Dr. Victor C. Carroll of Cambridge has been elected president of the Dorchester County Medical Society.

Dr. Andrew J. Crowell, class of 1893, has been elected president of the Mecklenburg County Medical Society, N. C.

Dr. Guy W. Latimer, class of 1901, of Hyattsville, Md., has been elected president of the Prince George's County Medical Society.

Dr. Edward Lake Jones, class of 1901, of Cumberland, Md., has been elected president of the Allegany County Medical Society.

Dr. Charles J. Davidson of Easton, Md., has been elected president of the Talbot County Medical Society. Dr. Philip Lee Travers of the same town and Dr. James A. Ross of Trappe were elected vice-presidtnts; Dr. Clifford M. Steele of Cordova, secretary-treasurer, and Drs. Samuel C. Trippe, Royal Oak; William S. Seymour, Trappe, and S. Denny Willson, Easton, censors.

Dr. George R. Patrick, class of 1879, of Lowell, N. C., has been elected president of the Gaston County Medical Society.

The many friends of Dr. Henry H. Weinberger will be glad to hear that he has received several good offers of hospital positions in New York city. He has, however, decided to remain at St. Gregory's Hospital, where he is an assistant physician.

The board of trustees of the permanent endowment fund of the University of Maryland met recently at the office of the president, Judge Stockbridge. There were present Judge Henry Stockbridge, Dr. Samuel C. Chew, Dr. Eugene F. Cordell, Dr. Harry Adler, Dr. B. Merrill Hopkinson and J. Harry Tregoe, Esq. Officers for the year were elected as follows: President, Judge Stockbridge; secretary-treasurer, J. Harry Tregoe. Executive committee, the officers and Drs. Chew and Hopkinson.

The treasurer presented the report, showing the fund of $20,340.75 to be invested in good securities. By the charter the board can only expend the interest of the fund.

Besides the permanent fund, the faculty of

physics holds two medical scholarships of $250 each. Two revisionary bequests have also been made to the university, one estimated at $100,000 and the other $45,000.

The university owns 15 buildings and the ground on which they are situated, on the four corners of Lombard and Greene streets.

Dr. Herbert Harlan, chief surgeon of the Presbyterian Eye, Ear, Nose and Throat Hospital, was presented a silver loving cup at a reception tendered by the board of lady managers of the institution recently. The presentation took place in the hospital. Dr. Harlan has been on the hospital staff for 30 years.

Dr. and Mrs. George A. Fleming have returned home after a pleasant vacation spent at Atlantic City.

A large bridge and five hundred party was held at the Arundel Club recently, under the auspices of Mrs. Howard Towles, for the benefit of the University Hospital.

Dr. Hiram Woods gave a lecture to the boys of the H. H. H. H. Club on the eye. The club is to help working boys help themselves.

Members representing the senior class on *Terra Mariæ* editorial staff are John W. Abbitt, editor-in-chief; John Moody Blodgett, coeditor, and Louis Rubin, class editor.

Dr. B. Merrill Hopkinson has been re-elected president of the Baltimore Athletic Club.

Dr. José L. Romero, class of 1870, was presented with a silver loving cup on the occasion of his relinquishment of the position of Health Officer of Jacksonville Fla.

Dr. Charles E. Terry, class of 1903, has been appointed Health Officer of Jacksonville, Fla.

Dr. William L. Hart, class of 1906, United States Army, has been transferred from Washington Barracks to Cebu, P. I.

Dr. J. G. Hollyday, class of '68, of Baltimore, has gone to North Carolina on a hunting trip.

Dr. Frank W. Weed, captain, United States Army, has left Fort Totten, N. Y., on ten days' leave.

Dr. R. A. Shankwiler, class of 1909, assistant resident physician at Eudowood Sanatorium, has resigned to accept a similar position at the Antituberculosis Association Sanatorium, Louisville, Ky. Dr. Shankwiler is a graduate of the medical department of the University of Maryland, and is a native of Pennsylvania, but has lived in Baltimore 15 years. Dr. Shankwiler worked at Eudowood under Dr. A. M. Forster, and will take up his new work at Louisville with the same affiliations. He will be succeeded in his position at Eudowood by Dr. F. H. Vinup, also a graduate of the medical department of the University of Maryland, class of 1909, and formerly resident physician at Bayview.

The Chi Zeta Chi Fraternity gave an intercollegiate dance at Lehmann's Hall January 22, 1910. Among the patronesses were Mrs. Randolph Winslow and Mrs. J. Fred Adams.

The semi-annual senior dance of the University of Maryland and St. John's College was held at Lehmann's Hall December 16, 1909.

Dr. Walter Franklin Weber, class of 1909, of Alberton, Md., who has been confined to the University Hospital for some time, has been removed to the home of his father, in Cumberland, in a very serious condition. We are sorry to report that he in al probability has not long to remain in this world. A large tubercular kidney was removed during the latter part of last year, since which he has developed a general tuberculosis.

Dr. W. J. Coleman of the resident staff of the University Hospital has returned from a 10-day trip to Boston and New York.

Dr. J. Whann McSherry, class of 1855, writes: "I have always had high regard for my old teachers, and all through life I have met, associated and consulted with many of the university's sons, and have always been proud to find them active, capable, conscientious gentlemen."

Dr. A. A. Matthews, class of 1900, formerly superintendent of the University Hospital and now a resident and practitioner of Spokane, Wash., is

being congratulated upon the birth of a baby daughter.

Dr. Arthur M. Shipley read a paper—"Report on Cases in Which Abdominal Pain Was the Only Symptom"—before the section on clinical Medicine and Surgery, Baltimore City Medical Society, Friday, February 4, 1910.

Dr. E. R. Russell, class of 1895, of Charlotte, N. C., was presented with a silver loving cup by his professional confreres on the occasion of his removal from that city to Asheville, N. C.

Dr. Philip Lee Travers, class of 1902, and Mrs. Travers, of Easton, Md., are visiting Dr. and Mrs. J. E. Muse, 1520 Hollins street, Baltimore.

Dr. Richard H. Lewis, class of 1871, of Raleigh, N. C., has been elected president of the Wake County Medical Society.

The following appeared recently in one of the daily papers: "Some folk go to the seashore for their vacation, and some to the mountains. Dr. T. A. Ashby of Baltimore goes to the Legislature, and he gets as much fun out of it as a bridal couple at Niagara Falls. Takes his mind off his regular work, he explains, and at the same time gives him something to do, for not even the most imaginative mind could associate Dr. Ashby with idleness. As chairman of the House Committee on Hygiene, Dr. Ashby finds congenial work, while he is also enthusiastic over the measures he has so far introduced. His legislative duties may be vacation diversion for him, but they would look like mighty hard work to most men."—*Baltimore Sun.*

The following graduates of the University of Maryland passed the recent examination of the Maryland State Board of Medical Examiners and received licences to practice in Maryland: William H. Daniels, class of 1907; James H. Bay, class of 1908; Henry H. Weinberger, class of 1908; Branch Craig, class of 1909; John N. Osborne, class of 1909; Lyttle N. Patrick, class of 1909; Harry M. Robinson, class of 1909; John T. Russell, class of 1909; Frederick H. Vinup, class of 1909. Dr. Branch Craig attained the second rating upon the examination, receiving a general average of 90. Dr. Craig led at the North Carolina examination, with a general average of 96.

The class officers for 1910 are as follows: President, Frank Paul Firey; vice-president, R. R. Diller; secretary, C. M. Devilbiss; treasurer, E. H. Kloman; treasurer, A. L. Little; historian, H. N. Knight; prophet, M. J. Firey; class orator, G. S. Condit; class artist, M. G. Hoffman. Executive committee, W. A. Gracie, chairman; E. B. Owens, J. H. Von Drelle, J. E. Talbott, T. Brooks, J. E. O'Neill.

MARRIAGES

Dr. William J. Corse, class of 1872, of Gardenville, Md., was married Wednesday, January 26, 1910, to Miss Ethel Gordy, daughter of Mr. and Mrs. William P. Gordy. The marriage was performed at the home of the bride, 2326 East Hoffman street, by Rev. J. S. Bower, pastor of Ahnutt Memorial Methodist Protestant Church. Immediately after the ceremony Dr. and Mrs. Corse left for their future home on Southern avenue, Gardenville. The couple will leave in about a month for a two weeks' trip to Florida.

DEATHS

Shortly after noon February 3, 1910, in a boarding-house on West Fayette street, Elijah Baba Badel, a Persian Mohammedan, and a second-year student of medicine in the medical department of the University of Maryland, shot and killed Miss Marie Lewsen, a Jewess and a member of the dental class of the University of Maryland, and then committed suicide by firing a bullet into his own breast.

The cause of the homicide and suicide is said to have been unrequited love. Miss Lewsen was from Los Angeles, a suburb of Portland, Maine, and was 24 years of age. She spent a year at Tufts College before matriculating at the University of Maryland.

Badal was 31 years of age, and was born in Urina, Persia. Before entering the University of Maryland he spent a year at Harvard.

Dr. Thomas A. R. Keech, class of 1856, a native of Maryland and one of the few survivors of the class of 1856, and who for the last 50 years has been one of the most prominent practitioners of the city of Washington, D. C., died at his home January 31, 1910. Interment was at Beltsville, Md. A graduate of the medical department of the University of Maryland, class of 1856, Dr. Keech the following year settled in Washington,

where his professional career was enacted to the time of his demise. He is survived by his widow, two daughters and a son, J. R. Keech.

Dr. J. O. Dorsey, class of 1862, one of the best-known residents of Calvert county, died at his home near Broome's Island of congestion of the brain January 4, 1910. Dr. Dorsey was 67 years old. He was a graduate of the medical department of the University of Maryland. For a while he practiced in Baltimore in the offices of Drs. Doyle and Hinsley. His last years were spent as a successful farmer. He leaves a widow, who was Miss S. E. Holt, and nine children—Mrs. F. G. Fisher, Mrs. G. R. Barnes, Mrs. C. W. Skinner; Misses Grace and Emmaline Dorsey, and Messrs. Alexander, Julius, Clement and Reginald Dorsey. The funeral services were conducted by Rev. B. B. Lovett. Burial was in the family lot.

Dr. William Beall, 89 years old, one of the oldest residents of Morgan County, West Virginia, died at his home in Rock Gap District recently. Besides having been a successful practitioner, for many years he was also a minister of the United Brethren Church. He was educated in Columbia University, National University and the University of Maryland. He graduated as Doctor of Medicine from the National University in 1846, and took a post-graduate course in the University of Maryland in 1850. He began the practice of medicine in the vicinity of Washington and Baltimore as an associate of that celebrated physician and surgeon Dr. Dunbar until 1856, when he removed to Boonsboro, Md., where he continued in practice until 1872. He then entered the United Brethren ministry. In his newly-chosen field he labored until 1881, when he removed to Morgan county, West Virginia, and resumed the practice of medicine, in which he was very successful. Dr. Beall was twice married. His first wife was a Miss Jones, daughter of Commodore Calisby Jones, U. S. N. She lived but three years, and left him with two children. In 1856 he was married to Miss Rebecca Poffinbarger. To them seven children were born, three surviving—Mrs. Sallie Wilson of Jones' Spring, W. Va.; Mrs. Mannie Custer of Rock Gap District, and Rev. J. W. H. Beall of Baltimore.

While attending Albert Carroll, a nephew of John Lee Carroll, former Governor of Maryland, Dr. William P. Compton, a prominent practitioner and well-known member of the Metropolitan and Chevy Chase Clubs, Washington, D. C., dropped dead Feburary 1, 1910, of neuralgia of the heart.

Dr. Compton for some days had been attending Mr. Carroll at the home of the latter's father-in-law, Mr. Henry C. Perkins, at 1701 Connecticut Ave. N. W. When he called there February 1 he complained of feeling ill, and asked for a hot-water bottle. Soon he said he felt better, but in a few minutes he fell to the floor. Professional aid was immediately summoned, but when it reached him he was dead.

Dr. Compton was a son of the late Barnes Compton, for many years a member of the Maryland delegation in Congress. He was born in Charles county, Maryland, and received his education at the University of Maryland and Georgetown University. For the past 20 years he had been engaged in active practice in the city of Washington. He is survived by his wife, who was Miss Jean Harriot of New York, daughter of Samuel Harriot, and two children, Samuel Harriot Compton and William Penn Compton, Jr.

Dr. Charles Thomson, class of 1867, of Baltimore, Md., 68 years of age, died January 15, 1910, at the home of Mrs. H. R. Besant, East Church street, Frederick, Md., of pneumonia. Dr. Thomson and his wife came to Frederick Christmas to spend the holidays with their daughter, Miss Alice F. Thomson, a trained nurse of the staff of the Frederick City Hospital, and while there he was seized with the illness which resulted in his death. He was born in 1842 at Taneytown, Md., and for many years was a practicing physician at Middleburg, Carroll county. Besides his widow, Mrs. Elizabeth Thomson, and his daughter in Frederick, he is survived by another daughter, Miss Mary E. Thomson.

Dr. W. H. Clendinen Teal, class of 1897, of 1335 North Caroline street, Baltimore, died January 28, 1910, at his residence. The funeral services, held Monday, January 31, 1910, were conducted by Rev. W. H. Baylor of Grace Baptist Church; Rev. Edgar T. Read, Mount Lebanon Methodist Protestant Church; Rev. Dr. J. S. Bowers, Allnutt Memorial Methodist Protestant Church, and Rev. David T. Neely, Aisquith Street Presbyterian Church. Burial was in Greenmount Cemetery.