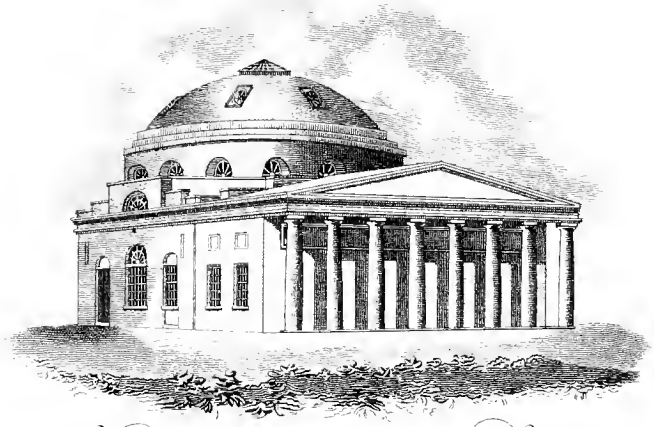

THE HOSPITAL BULLETIN

OF THE

UNIVERSITY OF MARYLAND

VOL. VII. MARCH 15, 1911. No. 1

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The Hospital Bulletin

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THE BULLETIN is conducted by a committee of the Hospital Staff, and will be devoted to the publication of Hospital material, to the educational interests of the University of Maryland and to the interests of the Alumni of the University, wherever found. Its functions will be educational and social, its promoters having in view the advancement of the educational work of the University from a clinical standpoint and the general welfare of the Alumni of the University by bringing them into more cordial relations and into closer affiliation.

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SOME PRACTICAL POINTS REGARDING FRACTURES, WITH SPECIAL REFERENCE TO INTERNAL DEVICES AND THE X-RAY.*

By A. Aldridge Matthews, M.D.,
Class of 1900.
Visiting Surgeon to St. Luke's Hospital, Spokane, Wash.

There has been considerable written in regard to the open method of treating fractures, but there is a great diversity of opinion still prevailing.

Dr. Lane claims that the open method should always be followed, when circumstances and conditions are favorable for such, but I certainly cannot agree with him in this matter.

While there have been great strides made in bone surgery in the past fifteen years, I do not think it has advanced as much as surgery of the abdomen and other parts of the body, and the credit of this advance is much due to the efforts of Scudder, Downey, Hodgen, Simpson, Whitman, Koche and many others who have contributed largely to this class of surgery, such as Krause, whose ambulatory treatment has added much to the comfort of patients and unquestionably saved many lives, especially in the old, who would otherwise die of pneumonia if it were not that they could be moved about and move themselves.

Also the introduction of antiseptics, anesthesia and the X-Ray has made bone surgery comparatively easy to what it was before. The X-Ray has been of great help in detecting obscure fractures and has helped much in the reduction of fractures; at least we can be fairly certain as to the position of our fragments and can be able to give a reasonably certain prognosis as to the result. The X-Ray has also been responsible for many mal-practice suits, which, if it were not for this instrument, these suits would not be. And the reason for this is that we may have a perfectly good and useful result with very little deformity, but if we take an X-Ray we will see that the reduction was not perfect and our alignments are far from being anatomical, but we have a functionally good extremity.

The X-Ray cannot be taken as a criterion, for we must remember that the negative is only a shadow which is reflected upon the plate, and a man not accustomed to this special class of work is likely to interpret these shadows wrongly. The positions in which these pictures are taken are very important. A tricky X-Ray man might exaggerate a condition very much by knowing how to cast or reflect the shadow, and this introduced into court has great weight with a sympathetic jury, when in reality the deformity may be small and the result fairly good.

Another great mistake which is often made with the X-Ray is by taking a negative in only one position; this is shown by figures 7-A and 7-B. If this negative was taken in one position, as 7-A, and no other were taken, it would be considered a fair alignment, but by taking it laterally you see it is far from being in good position.

Then again, look at Fig. 3-B. There is a great overriding, and the patient did not know he had this deformity until he had seen the negative, and in this case, while I do not suppose it was intentional on the part of the attending physician, it was fortunate for the patient on account of the great shortening in the other leg. This case I will speak of later. Scudder has said an approximate reduction that is non-anatomic, if followed by union and by a functionally useful part and no apparent deformity to the patient and his non-professional friends, is a good result.

Coming back to the subject of operating on fractures, as a whole it should be condemned in my judgment. Of course, in many cases it should

*Read before the Spokane Medical Society, Spokane, Wash., February 2, 1911.

be done; for instance, when we cannot reduce the fracture, when there is interposing tissue between the fragments, in oblique fractures where

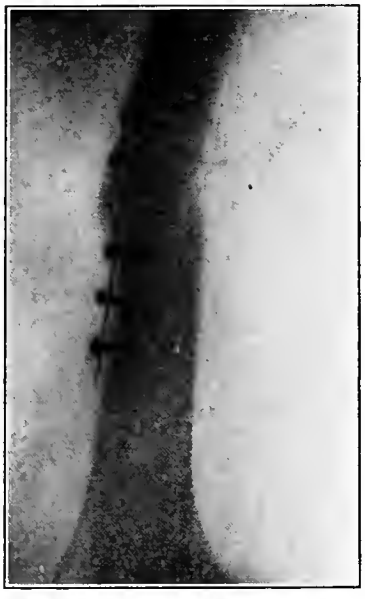

Fig. 3-A.—Application of silver plate to fractured femur, taken several months after being applied.

the muscular contraction causes overriding, or in any condition where a fairly accurate reduction cannot be had and maintained. The most certain

Fig. 3-B.—Old fracture of femur, showing strong union with great over-riding. The same patient as 3-A, but opposite leg.

way to determine this is by the X-Ray. Many times I have reduced fractures, at least thought I had, and after putting them up in splints found by a radiograph that I was much mistaken. This has happened several times in fractures of the tibia, and in all of these cases I have usually had to resort to the open method to accomplish the desired result.

The fracture of the patella is a fracture which, as a whole, under favorable conditions, should be treated by the open method. Other types of fracture which should come to operation to get good results are fractures of the neck of the femur (not in the old, but in the young) and those of the olecranon. But there are some who even condemn operating upon the patella, even though nearly always the ligament tears off not evenly

Fig. 3-C.—Bone removed from middle third of femur (3-A) before applying plate.

with the bone and usually interposes between the fragments.

Another mistake which I think we often make is that of trying to reduce fractures without an anesthetic. We often fail to get a good reduction while our patient is awake, for naturally he resists, even though unintentionally, and especially is this a mistake if we cannot have a radiograph to be certain after the reduction to see if the position of our fragments is in good alignment.

A very much abused, if I might say, fracture is the Colle's fracture, and we often see bad deformities following this fracture, which is usually due to not having been properly reduced or only

partially so doing, and here an anesthetic is practically always necessary.

I have a man here in town whose wrist I am ashamed of, not that he has not a perfectly useful hand, as practically all of them do get this, but he has a bad deformity. The only excuse I have to offer is that he was on a debauch which lasted some days after the accident, and it was a very hard matter to keep any dressing on his arm. Usually a properly reduced Colle's will remain in position and need but a light dressing. The dressing which I prefer is the plaster splint.

The proper time to operate on fractures should vary. If a compound fracture, an immediate

Fig. 4-A.—Fractured tibia and fibula, taken through cast.

operation should be performed if such is necessary to keep the fragments in position. In such fractures there is already a solution of continuity and it will not add anything to the danger of sepsis or the probability of death if we treat the fracture by the open method, simply enlarging the wound already produced. But if not compound, it is better to wait a week or ten days, as Murphy has suggested, because the tissues are then in a condition of least resistance and after a week or ten days one can do an enormous amount of work without danger of infection, which could not be done on the day of the accident. The lymphatics have been cofferdammed and the new capillaries are developed to the greatest resistance against microbic invasion. But there is one objection to this waiting, and that is the muscular contraction which so often occurs, which makes it

Fig. 4-B.—Same as 4-A, taken through plaster cast after reduction and application of silver plate.

almost impossible to reduce our fracture, and it becomes sometimes necessary to resort to myotomy and tenotomies, which is not always an

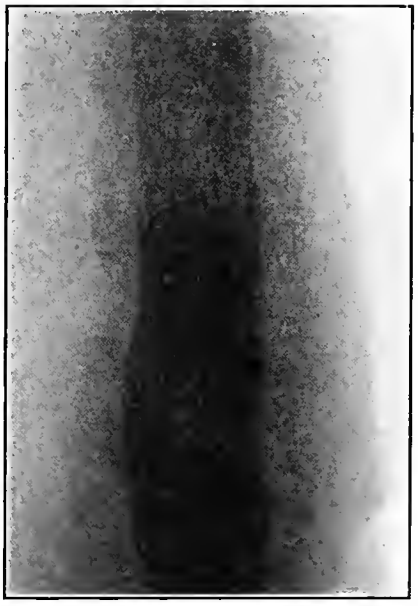

Fig. 5.—Results following wiring of femur. Wire removed.

advisable operation, although I had to do so in one case, which Fig. 8 represents.

There is such a thing as waiting too long, which,

no doubt, all of us who do surgery have seen, and that is bone softening, spoken of by A. F. Jonas as physiological bone softening. This being a

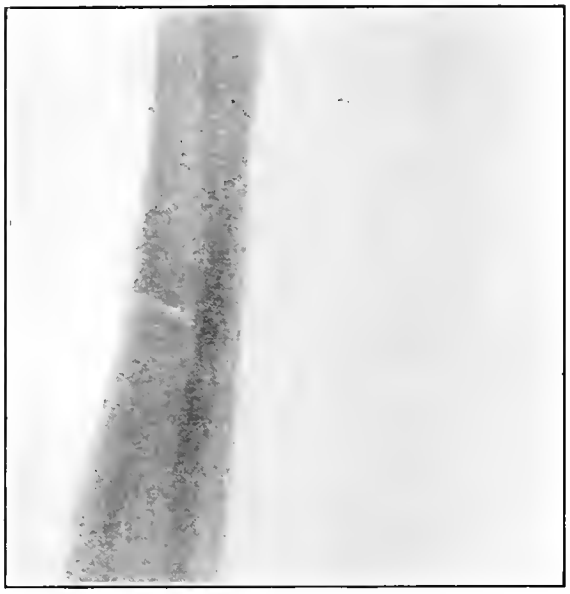

Fig. 6-A.—Lateral view of fractured tibia and fibula after reduction.

process of repair which takes place in bone, noticeable after two to three weeks, becoming more marked as time passes on, until the calcium salts

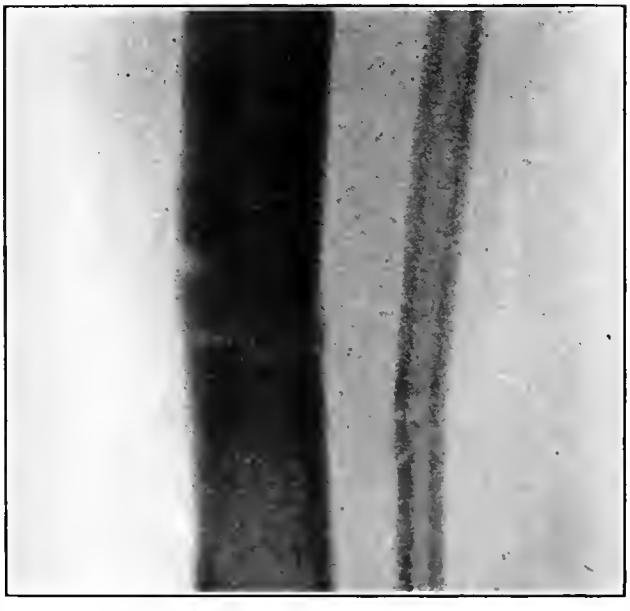

Fig. 6-B.—Same as 6-A, anterior posterior view.

begin to predominate and the density increases and the reverse process is carried on until the normal density of the bone is re-established. This is one reason why splints, wires, nails, etc., do not hold and pull out easily when we operate upon old fractures, such as ununited fractures of six to ten weeks standing. This softening is shown very nicely with the X-Ray by the lesser density of the fractured extremities.

In a new fracture any device which will hold the fragments in position is the correct one, whether externally applied splints or the application of internal devices. If it be the internal one, such as nails, screws, wire, staples, or what not, we must remember that they only hold for a short while and not until the union is complete. We usually have to remove these materials sooner or later, and they are always perfectly loose. I have many cases where these materials have not been

Fig. 7-A.—Old fracture of femur, anterior posterior view.

removed and some of several years standing. One case has had silver wire in the tibia for eight years.

The loosening of these devices is due to the lime salt being absorbed around these foreign bodies, therefore we can only expect these materials to act until the main factors cease to operate, and that is muscular contraction, which is overcome in about one week, so by proper internal device and proper external support this can usually be accomplished. The materials that I am most partial to are the silver plate, wire and nails, but on a number of occasions I have used silkworm gut, chromic gut, screws and celluloid linen.

The ivory screws of Magnuson, spoken of by De Forest Willard, with metallic heads are considered very good, although I have never used them. These screws are screwed into the bone and cut off flush with the periosteum, and it is claimed they soon become part of it. I feel a little skeptical about this and cannot see why they would be any more satisfactory than the metallic screws.

I am not in a position to speak of the bone clamps for holding fragments in position, or the fracture devices which extend from the bone to the outside, as I have never used them. As a whole, for long bones, I prefer the silver plate held by screws, for it will hold and give, which the steel plates will not do, and is less liable to

Fig. 7-B.—Same as 7-A, except taken laterally.

pull out the screws if strain is put on, as can be seen in Fig. 3-A. See how the plate has bent.

I would like to show you a few X-Ray negatives which will throw a little light upon what I have been talking about.

Figs. 3-A and 3-B represent a man hurt in a wreck in which he had both legs fractured. I did not see him until about ten weeks after his injury, and at that time he had an ununited fracture of his right leg, with a great deal of crepitus and a number of sinuses running pus scattered all along his mid thigh. An amputation had been advised and he was sent here for that purpose.

After examining him I advised a resection and removal of about the middle third of his thigh

Fig. 8-A.—Bowing of tibia and fractured lower end fibula, anterior posterior view.

Fig. 8-B.—Same as 8-A, lateral view.

bone, for it was very plain to see that the fracture was comminuted and a quantity of dead bone

was present. The right leg was united as Fig. 3-B represents.

On September 21, 1909, I opened and removed two large spicules and then resected both of the ends of the femur, which you will see in Fig. 3-C. If you will notice, most of the bone removed is

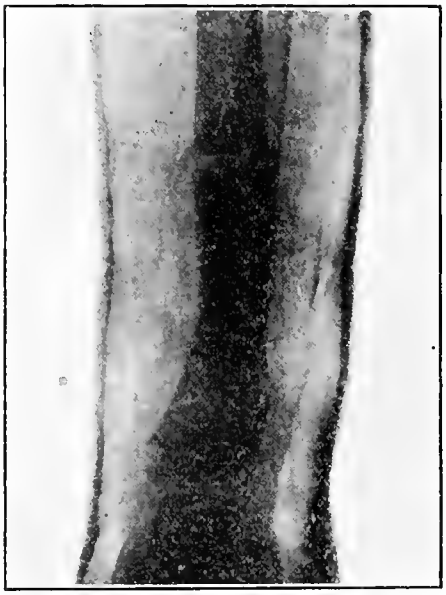

Fig. 8-C.—Same as 8-A, after straightening tibia and resecting end of fibula. Radiograph taken through cast.

dead and some of it had a worm-eaten appearance, showing absorption is taking place. Then I applied a silver plate with three screws below and two above, which is shown very well in plate Fig. 3-A. After a very protracted stay in the hospital he managed to get a good useful leg which he can walk about on very well, although it is about six inches shorter than it was before the accident, but he wears a high shoe on this foot and uses a cane. Fortunately, the other leg is about four inches shorter than it was formerly on account of the over-riding, which is shown in Fig. 3-B. This may be called a fortunate mistake.

In Fig. 3-A the slight bending of plate and a little misplacement of ends is possibly due to the position in which it was put up following the operation, for there was naturally great mobility following the operation and the soft parts were puckered up in the middle thigh, which gradually contracted and took care of the slack. He is quite an active man now, and the plate is still in position and gives him no trouble.

Figs. 4-A and 4-B represent a young man who had his leg broken by direct violence.

I attempted to reduce this fracture, but could not, so put it up in plaster and had an X-Ray taken, which is shown in Fig. 4-A. The next day I opened down upon the fracture and tried to reduce, but on account of the muscular contraction I could not do so, even though the fracture was not more than ten days old, so had to resect and applied a plate, which is shown in Fig. 4-B. This man I kept under observation about three weeks, and he then went down in the country. I have gotten most satisfactory letters from him and his physician. The X-Ray was unfortunately taken too high up and does not show the exact result following the application of the splint. It also shows a comminuted fracture of the fibula. I did nothing to this bone, for it only being for muscular attachment, etc., and I felt certain that it would get sufficient union without resorting to any operative treatment.

This has been over a year and the plate has not given him any trouble, and his physician recently reported to me he had an excellent result.

Fig. 5.—Male, aged 28, fractured thigh, upper middle third. This man was anesthetized and

Fig. 8-D.—Same as 8-C, lateral view.

fracture reduced and put up with traction, short inside splint and long outside splint, but after about nine weeks found he had no union, so opened down, freshened up the ends of the fragments, which were in fair apposition, and put a silver wire suture through the two fragments, but

this wire I had to remove about the tenth week after the operation on account of its setting up considerable irritation, and a sinus developed, also a small spicule of bone about the size of a pea came away and then the track immediately healed, and, as you see, he has a very good result, only a little thickening of the shaft.

Figs. 6-A and 6-B.—Male, age 34, shows nothing except a rather unusual fracture of the tibia and fibula and a good apposition, the kind we would like always to get, it being comminuted.

Figs. 7-A and 7-B show strongly the great advisability of taking two views of a fracture. If we had only had the one, as Fig. 7-A, we would consider it a fair result, but by taking another view we find it is far from being what we want. This is a posterior deformity and does not inconvenience him, and he told me a few days ago he had just walked nine miles on it, and he was satisfied to leave it as it was.

His attending physician at the time of his accident was surprised, for he thought that he had gotten an excellent apposition, but the apposition, as it is plain to be seen, is very poor. The ultimate outcome and usefulness of his leg is good, even though the deformity is much, but being a convex deformity posteriorly it is not apparent to him.

One disadvantage most of us have is the inability of having the femurs X-Rayed on account of not being able to get them to an X-Ray or an X-Ray to them to see the position of our fragments, for it is impossible to be absolutely certain that our fractures are always in correct apposition, and I consider this one reason why so often there are ununited fractures of the femur.

Fig. 8 shows the radiograph of a little girl, age five, who was referred to me on account of lameness. The child gives no history of ever falling or receiving any accident, although you can plainly see by the radiograph that she has a fractured fibula near the lower end. It is also very apparent that this had been done some time before on account of the callus thrown out around the fracture. And, too, this child was inclined to walk upon the toe and turn the foot in. The tendo Achillis was very tight. I think possibly what must have happened was that the child had some time an accident, because the fracture could not be produced other than by violence, which fractured the fibula and bowed the tibia. I put the child to sleep, fractured the tibia about between the middle and lower third, correcting the deformity as much as I could; also removed a small part of the fibula because it projected out and the skin was tight across it.

Figs. 8-A and 8-B show leg before the operation; 8-C and 8-D show the leg a few days after the operation. I found it necessary to cut the tendo Achillis to hold the foot in proper position. I opened down on the tendon, cut it across, but not the sheath, and then put a celluloid linen mattress suture in the tendon, uniting it, or otherwise bridging the space over with the suture, leaving a gap of about one-half to three-fourths of an inch. This child has gotten a very good result, although I cannot say as to the ultimate outcome. It has now been about three months since removing splint, and result is apparently excellent.

Dr. William Franklin Twigg, class of 1857, is one of the leading physicians of Allegany county. He was born in Allegany county April 14, 1857, the son of Francis Twigg and Catherine Gelichman, and is of American-German ancestry. He obtained his early education in the public schools of the county and the normal school at Bedford, Pa. He then taught school for nine years in Allegany county, and in 1881 matriculated at the University of Maryland, graduating from there in 1883. During his senior year he was a resident student at the University Hospital. He began his professional career at Elk Garden, W. Va., and after practicing there for three years he located permanently at Cumberland, Md., where he has since lived. He married March 23, 1887, Miss Sarah M. Hetzel, of Cumberland, and has three children—Mirian Catherine, Ethlyn Marguerite and Nial Franklin Twigg.

In politics Dr. Twigg is a strong Republican. He is surgeon to the Baltimore and Ohio Railroad at Cumberland, and special surgeon for the legal department of the company. He is also a member of the board of pension examiners for Allegany county, and physician at Allegany County Insane Asylum. He is a member of the Medical and Chirurgical Faculty of Maryland, the American Medical Association, the International Association of Railway Surgeons and the Allegany County Medical Society.

TETANUS.*

By Alvin Clay McCall,
Class of 1910.

Tetanus, or lockjaw, is an acute infectious disease characterized by tonic, muscular spasms, generally extensor in type, occurring at longer or shorter intervals, occasionally aggravated by clonic spasms, these being limited to the jaws or all the muscles of the body.

ETIOLOGY.

Tetanus is due to bacillus tetani, discovered by Nicolaier in 1884 and grown in pure culture by Kitasato in 1889. The organism is widely distributed; found in garden soil, manure piles, hay, etc. Occurs in dirty localities, especially among the negroes of the South, but also prevalent in Pennsylvania, Northern New York, New Jersey and Long Island, endemically in New Jersey and Cuba, and is a common sequence to the Fourth of July accidents.

Tetanus gains entrance into the body most often through punctured or lacerated wounds, abrasions, toy-pistol wounds; in fact, any accident following which the wound is contaminated with dirt. Has been seen to follow vaccination where contaminated with organisms and hypodermic injections of animal serum. Gains entrance in infants through umbilical cord. The wound frequently suppurates or sloughs before the symptoms of tetanus appear. From point of inoculation the organism grows anerobically, elaborating toxins, which may spread so rapidly as to cause death in 24 hours (Holt). The toxins enter the motor end nerves, traveling by lymph and axis cylinder to spinal cord, then up the motor tracts to the medulla. The action of the toxins on the motor nerves directly and reflexly cause tonic convulsions, and on the sensory nerves cause clonic convulsions.

PATHOLOGY.

Pathology is very obscure; no organisms found in blood or internal organs. Membranes of the cord and brain are reddened; small hemorrhages into the brain substance and muscles. Ganglion cells of the cord undergo degenerative changes (lesions which are common to many toxic diseases).

SYMPTOMS.

Incubation average is from 7 to 10 days; one case reported 12 hours after accident (Kuhn); another four weeks (Groose). First is trismus of the jaw and difficult deglutition, followed by rigidity, jaw being set, and then followed by rigidity of the entire body. Occasionally the arms escape. Rigidity lasts at first from one to two minutes, occurring every 15 to 20 minutes, and then increases in frequency until it is continuous; then produces the characteristic widespread tonic convulsions aggravated by clonic. Patient is in a hyperextended condition, opisthotonus position; face is drawn, set, eyes fixed, causing a peculiar sardonic smile. Speaks with difficulty, cannot swallow, mouth closed, obstinate constipation and retention of urine. The convulsions grow worse until each clonic spasm, fixing diaphragm and chest muscles, may cause death. Patient is in some unnatural position, face cyanotic, wet with perspiration, eyes bulging, countenance expresses deadly terror and suffering. Each clonic spasm forces air out through the glottis, causing hissing scream. Spasms are due to peripheral irritations brought on by slightest cause, as drafts, speaking, weight of bed clothes, etc. In cases of recovery above symptoms become less severe and finally cease. If death, increase in severity. Temperature normal, or 101° to 102°. Pulse, high tension rate, 80 to 100 per minute. Mind clear; insomnia obstinate.

Chronic tetanus comes on in from 10 days to several weeks; spasms not so severe; periods of relaxation permitting sleep.

Cephalic Tetanus. — Spasms confined to the face, pharynx and neck.

DIAGNOSIS.

As it is impossible to isolate the bacillus in many of the cases, the diagnosis is based upon the characteristic tonic and clonic spasms beginning in the jaw and involving the body, the opisthotonus, sardonic smile, clear mind and very low temperature, but may be confounded with hysteria, strychnine poisoning, tetany and hydrophobia.

The following points are helpful in differentiating:

1. *Tetanus — History of Wound.*—Muscular symptoms commence with pain and stiffness in the back of the neck, twitching of the jaw, same being affected first, then rigid and set.

Hysteria—History of Excitent Nature.—Muscular symptoms commence with rigidity of the neck, which creeps all over the body, affecting

*Read before the University of Maryland Medical Society, November 15, 1910.

the extremities last; jaws set before convulsions and remain so between convulsions.

Strychnia Poisoning—History of Taking Drug. Muscular symptoms come on rapidly, beginning in the extremities and body simultaneously; jaws last affected, and its muscles relax first after convulsions.

2. *Tetanus.* — Persistent muscular rigidity, generally with a greater or less degree of permanent opisthotonus.

Hysteria.—Persistent opisthotonus and intense rigidity between convulsions, lasting for a few minutes.

Strychnia Poisoning.—Muscular relaxation between convulsions; patient exhausted and sweating.

3. *Tetanus.* — Consciousness preserved until near death.

Hysteria.—Consciousness disturbed as second convulsion comes on and thereafter.

Strychnia Poisoning.—Consciousness preserved unless death is imminent from suffocation.

4. *Tetanus.*—Eyes open and rigidly fixed during convulsions.

Hysteria.—Eyes closed during convulsions.

Strychnia Poisoning. — Eyes stretched wide open.

Tetany.—Milder nature of spasms, greater limitation of rigidity; spasms begin in the hands and feet, but not in the jaw or neck.

Hydrophobia.—Tonic spasms do not exist.

PROGNOSIS.

The longer the period of incubation, the less virulent the germ and the better chance of recovery. Mortality in young infants practically 100 per cent. Mortality in all cases from 80 to 90 per cent. Average duration of disease, three and one-half days after active convulsions set in.

TREATMENT.

Prophylactic.—This is most important when we recall the fact that we have no specific treatment, and the mortality is from 80 to 90 per cent. All wounds should be treated antiseptically. If made with dirty objects, or if wounds have become contaminated, they should be incised freely, cleansed and dressed antiseptically. Vaccinations and hypodermic injections should be made antiseptically. Antitoxins should be given in all doubtful cases which are suspicious in doses of from 1500 to 3000 units. Antitoxins have been proven experimentally to retard or prevent infection. As yet no harmful symptoms have been reported from the administration of same.

Surgical Treatment. — Always look for a wound. If found, incise, remove all necrotic tissue, disinfect, drain and dress antiseptically.

General and Medicinal Treatment. — Patient should be kept in a quiet room, catheterized if necessary, bowels made to move by purgation or enema, and patient stimulated freely with alcohol. Nourishment given by mouth if possible; if not, by rectum. Medicinally, all drugs of cerebral or cord sedatives have been tried, with occasional recovery. Large and frequent doses of chlorals, bromides, morphia, calabar bean and cannibus indica being used mostly. Antitoxin should be given in all cases, numerous cases of recovery following its use being reported. The method of administration is unsettled, good results having followed intradural injections either in the cord or brain. Dose, 1500 to 3000 units, repeated daily, and in very severe cases two or three times daily. Ten c. c. of 25 per cent. solution of mag. sulph. injected intraspinally has been followed by repeated recoveries, acting solely by its anesthetic effect on the cord, putting the patient at rest and saving him from exhaustion. The disadvantages of this, however, are the depressing effect on respiration and the collection of mucus in the lungs. This can be largely eliminated by elevating the head and giving atropine.

Hypodermic injections of emulsion or fresh brain matter has been recommended as the treatment to take up the toxins of tetanus, which has a mutual affinity for nervous tissue.

Carbolic acid in a solution of 3 per cent., injected deep, is supposed to render toxins inert, but is doubtful.

REPORT OF CASES.

D. M.—Admitted October 24, 1910; in service of Dr. Hirsh.

Age seven; occupation, school girl.

Family history negative.

Past history negative to any acute disease; had jaundice when child; vaccinated September 13, 1910.

Present Illness.—Thirty-three days after vaccination first signs of illness appeared. In the afternoon, October 18, 1910, on returning home from school, tripped over a stone and fell, cutting her lip. Walked home, but complained of feeling weak and stiff. She continued going to school the rest of the week. Three days later an erup-

tion of small pustules appeared over the body. On Sunday morning complained of difficulty in swallowing; later on in day began to have spasms, six to eight during the day. Nature of spasms: Jaws set and patient resting on back of head and heels, lasting a few minutes. Complains of being thirsty, and voids urine involuntarily during spasm. No spasm Sunday night.

Was brought into hospital Monday afternoon, October 24, 1910, 39 days after vaccination and the second day of convulsions. Patient was in tonic spasms, aggravated at intervals of 15 to 20 minutes by clonic spasms lasting three to five minutes, condition having persisted all day. Patient is helpless and in excrutiating pain; memory perfectly clear.

Physical Examination.—Patient is a female, white child, brought into the hospital in an extremely filthy condition. Body covered with dirt and head entirely overrun with pediculi. Talks with difficulty; mind is clear; expression of agonizing pain. At intervals cries out for help. Rigid, and position is that of opisthotonus, due to tonic spasms, aggravated by the clonic spasms. Difficult swallowing, and swallowing seems to increase severity of spasms, face becoming cyanotic.

Scalp covered with heavy coating of light brown hair, entirely overrun with pediculi; large number of small pustules over occipital region.

Eyes are set; has peculiar stare. Conjunctivæ slightly injected; pupils equal, react sluggishly to light and at times to accommodation.

Face muscles rigid, producing peculiar sardonic grin. Contused-looking area site of carbuncle under right jaw. Mouth set; muscles of mastication rigid; not able to force open more than one-eighth inch. Cannot protrude tongue. Teeth dirty, but sound. Impossible to examine throat.

Neck: Rigid, hyperextended; no palpable glands; vessels stand out prominently.

Chest: Hyperextended and rigid, covered with small pustules; respiration short, labored, and during clonic spasm is suspended from one-half to a minute.

Lungs: Negative.

Heart: Negative.

Pulse; Increased tension; rate, 125 per minute.

Abdomen: Covered with small pustules, marked rigidity, board-like. Cannot make indentations with finger.

Upper extremity: Perfectly rigid; cannot bend elbows; manipulation of arms increases spasms. Small pustular eruption over arms, and on left one there is a necrotic scab, site of vaccination. On pressure, pus exudes from beneath scab.

Lower extremities: Hyperextended; cannot flex legs; painful to manipulation; knee reflexes absent.

Nervous system: Mentally clear; talks only with difficulty and indistinctly; cutaneous surfaces hyperesthetic.

Examination increases severity of spasm.

Temperature: Admission, 101.2°; for six days ranged between 99 and 103.4°; since normal.

Pulse: Admission, 122; for six days ranged between 100 and 150; since normal.

Respiration: Admission, 28; for six days ranged between 20 and 30; since normal.

TREATMENT AND COURSE OF DISEASE.

Patient was given 1500 units of antitetanic serum, immediately after entrance, deep into the right gluteal region; also given morphia, grain 1-12th.

Patient was having tonic and clonic spasms every few minutes. Would have three or four clonic spasms every hour until midnight, when she was given another one-eighth of a grain of morphia, when clonic spasms ceased, but tonic spasms persisted. Restless entire night; no sleep; voids urine involuntarily.

Was given 1⅕ grains of calomel and ½ ounce of mag. sulph. W. B. C., 16,000. P. N., 85 per cent.

Second Day. — Rigid, but no clonic spasms. Drowsy at times; does not want to be disturbed. Takes water and milk through a tube. Tonic spasms increase after two or three swallows, face becoming cyanotic, lasting about a minute. Morphia, one-eighth grain, given in morning and evening; castor oil, 3 drams; mag. sulph., 1 ounce; vaccination scab removed; cultures taken on agar; one incubated and the other grown anerobically. Sore cauterized with carbolic acid.

Third Day.—Slept from 11 A. M. to 4 P. M., dozing at intervals thereafter. General appearance seemed better; takes nourishment easier; bowels moved freely after enema. 1500 units serum injected. Eyes washed t. i. d. with boracic acid and mouth with hydrogen peroxide.

Fourth Day.—Slept very little during night; general appearance brighter; no complaint of pain; frequently asked to have position changed; mouth can be opened one-half inch; pulse good;

agar cultures showed staphylococci. W. B. C., 16,000.

Fifth Day.—Slept very little; can be handled without pain; jaw muscles softer; can open mouth three-quarters inch and move head from side to side; arms move slightly. Vaccination wound cauterized and dressed. Morphia, 1-12th grain given.

Sixth Day.—Slept at intervals; much brighter; can move head freely in all directions; arms easily bent; mouth open one inch; eyes normal, except small pupils; probably due to morphia. Morphia, 1/6th grain given.

Seventh and Eighth Days.—Slept at intervals; opisthotonus disappeared; no risus sardonicus; bowels and bladder regular; no bacilli isolated from anerobic culture. W. B. C., 14,000. H. B., 74 per cent.

Ninth, Tenth and Eleventh Days.—Improving; sleeps entire night; legs can be bent to right angle; arms can be used to help herself; sluggish knee reflexes; mouth open to full extent.

Twelfth, Thirteenth and Fourteenth Days.—General appearance excellent. W. B. C., 9000. Sat up in chair.

Fifteenth, Sixteenth and Seventeenth Days.—Allowed to stand; complains of pain in legs; afraid to walk.

Eighteenth Day.—Walked one step, but stiff.

S. G.—Admitted October 6, 1909; in service of Dr. Hamburger.

Age 32 years; occupation, tailoring; social condition, widow.

Family history negative.

Past history: Had thyroidectomy performed two years ago. Two weeks ago had taken drugs to bring on menstruation, which lasted for three days. Womb was then curetted, and hemorrhage stopped. Ulcer was found, which was cauterized.

Present Illness.—Day before entering the hospital, about 12 days after curettement, patient awoke complaining of stiffness in the jaws, difficult swallowing; talking is difficult, and had convulsive spells. Body bathed in perspiration, and complaining a great deal of pain.

Admitted to hospital on October 7 at 1 A. M., having typical tetanic convulsions. Pulse weak; did not respond to cord or cerebral sedatives.

Admission temperature, 90°; temperature ranged between 99 and 104⅗°.

Pulse on admission, 120, ranging from 90 to 160.

Respiration on admission, 22, ranging from 20 to 42.

Patient ran a very severe course; continuous spasms; would not respond to sedatives. Patient was given 15 grains of bromide and 5 grains of chloral. No organisms isolated.

Died on second day of convulsions, 27 hours after admission to hospital.

M. K.—Admitted March 6, 1910; in service of Dr. Winslow.

Age 14 years; occupation, factory hand.

Family history negative.

Past History.—Ten days prior to present illness ran a rusty nail through the foot, which wound healed readily.

Present Illness.—Symptoms began four days ago; that is, 10 days after incurring wound, with stiffness and rigidity of the jaw, and rapidly developing into general convulsions. Temperature on admission, 100.5°. For three days temperature ranged from 98 to 102°. From the fourth to the sixth day, from 101⅗ to 103⅘°.

Pulse on admission, 102; for the first three days ranging from 80 to 130; fourth to the sixth day, from 80 to 135.

Respiration on admission, 24; ranging during the six days from 20 to 40.

W. B. C., 9600. H. B., 85 per cent. B. P., 120.

Had severe course of convulsions, and only after large doses of sedatives were the spasms suppressed. No organism isolated.

TREATMENT.

First Day.—Wound in foot opened; spinal puncture done under chloroform for cultures; 3000 units antitoxin serum injected. Patient was given 30 grains chloral and 60 grains bromide.

Second Day.—Was given 6000 units of serum and 10 c. c. of 25 per cent. solution of mag. sulph. intradurally.

Third Day.—Was given 6000 units of serum and 10 c. c. of 25 per cent. mag. sulph.

Fourth Day.—Was given 6000 units of serum, 40 grains bromide and 20 grains chloral; spinal puncture done and 6 drams of fluid withdrawn; 10 c. c. of mag. sulph. given.

Fifth Day.—Was given 6000 units serum, 10 c. c. of mag. sulph., 15 grains of bromide and 20 grains of chloral.

Last or Sixth Day.—6000 units of serum.

Received in all 30,000 units of serum, 70 grains

chloral, 115 grains bromide and 30 c. c. of mag-sulph. Nothing seemed to quiet the case, and gradually weakened until death, which occurred on tenth day, after six days in hospital.

FRACTURE OF OUTER THIRD OF CLAVICLE.

By S. E. McDaniel,
Senior Medical Student.

The clavicle derives its name from its resemblance to the old Roman key, "Clavis" Key. It is an S-shaped bone, situated between the head of humerus and scapula on outer side and sternum on inner side.

From its position and shape it can withstand a great deal of force. However, it is very liable to fracture, constituting some 15 per cent. of all fractures of body.

From an anatomical standpoint, the clavicle is divided into three distinct parts—an inner, middle and outer third. In point of frequency, the outer third seems the most liable to fracture. Rather just external to middle, where the inner or large curve meets the outer or small curve, at which point the bone is at its smallest diameter. Fractures of the outer end are more frequent than fractures of internal end, and much less frequent than fractures of the shaft.

Fractures may occur at any age, but perhaps are more common before the age of six. It is said more than half the fractures occur before this age.

It is caused by direct violence, indirect violence and, very rarely, muscular contraction.

The symptoms are:

Patient presents himself giving a history of injury to the shoulder. The peculiar way in which he is holding his arm and head would indicate that his collar-bone was injured. Likely he will be holding the elbow of injured side with hand of sound side, and pulling it against the chest. The head is turned down toward the shoulder of damaged side as if trying to listen to something in joint, thus relaxing the pull of sterno-cleido-mastoid muscle upon inner fragment. He will also have other symptoms of fracture, namely, pain, deformity, abnormal mobility and loss of function.

The pain will be increased by motion, pressure and hanging the arm down. The deformed shoulder will be shown by the pulling forward, inward and downward of the shoulder, with a reduction of the distance between the acromion and sternal end of clavicle. Abnormal mobility can be recognized by manipulating the fragments, and is usually accompanied by crepitus.

The course of healing is usually uneventful, and union takes place within a month in adults, but some persistent deformity is the rule.

Treatment consists in reducing the deformity by drawing or pushing the shoulder upward, backward and outward to its normal position, aided when necessary by pressure upon the projecting angle at point of fracture. The subsequent indication is to maintain the shoulder in this position, for the unsupported weight of the shoulder is the main cause of the displacement. This has been done satisfactorily in a great many ways. In children with a transverse, or a complete fracture, a simple sling for the forearm is often sufficient, but in oblique fracture of adults a perfect result can rarely be obtained. In girls, when the least amount of deformity is desired, we place them on a smooth bed with a firm, narrow pillow or cushion between the shoulders and the forearm resting on the chest. Sayre's dressing is in very general use. It requires two strips of adhesive plaster, each three inches wide and long enough to go once and a half around the chest. The end of strip is fixed loosely about the arm of injured side, just below the axilla, and the strip is carried around the back and the opposite side to chest in front, so as to hold the elbow a little behind the axillary line; the second strip is then carried from the top of shoulder on the uninjured side across the back to the opposite elbow up along the flexed forearm to the place of beginning, meanwhile pressing the elbow forward, inward and upward. A few turns of roller bandage about the arm and chest will give additional support. In this and all other similar cases care must be taken not to allow the bare skin of forearm to rest on that of the chest, in order to prevent maceration of the epidermis and even ulceration. Cotton wadding, linen or similar material should always be interposed between the two cutaneous surfaces.

Other bandages may be used for the purpose of holding the part in place, such as a figure of eight bandage of plaster of Paris.

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MD., MARCH 15, 1911.

THE ADVISORY ALUMNI COUNCIL.

On February 28, 1911, in the office of Mr. Walter I. Dawkins, was born another link in the chain which is working toward the creation of a new and greater University of Maryland. We refer to the Advisory Alumni Council, which began its formal existence on that date. It was certainly the privilege of a lifetime to attend the organization meeting of a body which in the future is of necessity bound to wield a powerful influence in shaping the destinies of our dearly beloved Alma Mater. Men from all walks of life were present—doctors, dentists, lawyers, pharmacists, etc. Enthusiasm was rampant in the fact that we had at last realized the fact that we were indeed going to be a factor in the internal direction of the University of Maryland; that we were going to be permitted to actually play our part as alumni and have a say regarding the policies of one of the oldest and noblest educational institutions in the United States. We were especially impressed with the fact that we were more or less burning bridges behind us and that the University of Maryland was entering into a new existence. Indeed, it was more or less celebrating a new birthday—a birthday dedicated to progress. Such were our thoughts, and if we read the signs aright we are not to be disappointed.

Although no definite lines of endeavor were laid down to follow at the first meeting, the Advisory Alumni Council did not waste time, but got down immediately to hard work. The president and secretary were chosen and inducted into office—Dr. B. Merrill Hopkinson and Mr. James W. Bowers, respectively. It was also decided to request of the Regents that they empower the various Faculties that the Advisory Alumni Council be given a vote in the selection of professors. The chair was empowered, besides, to select committees to investigate the feasibility and desirability of giving to the dental students a laboratory course in chemistry, another to look into the proper naming of the University buildings, and another still to seek a method to render the libraries more useful. We are only feeling our way, but expect to be able to render signal service to the old University. Anybody who has suggestions to make looking toward the betterment of our institution can do so with the assurance that the suggestion will be thoroughly investigated, and if thought wise and helpful will be brought to the attention of the University authorities. We are the connecting link between the Faculties and alumni, and hope that any alumnus who has the welfare of his Alma Mater at heart will avail himself of this privilege by addressing the suggestion to the president of the Advisory Alumni Council of the University of Maryland, namely, Dr. B. Merrill Hopkinson, Professional Building, Baltimore, Md.

NEEDS AND REMEDIES.

We are doing business at the same old stand. We are preaching on the same old text. The needs of the medical school are so numerous that it is difficult to specify wherein we are most needy. Certainly the time has arrived for the establishment of certain departments upon a full time, paid basis. These are, especially, chemistry, anatomy, physiology and pathology. The professors of these chairs should be scientists, and not practitioners of medicine. In our institution the department of chemistry is under the charge of two accomplished chemists, who are not physicians, but it would be an exaggeration to claim that they were receiving adequate compensation for their services. The departments of anatomy and physiology are under the direction of erudite and enthusiastic teachers, who also receive inadequate salaries, and who are engaged perforce in the practice of their profession as physicians. It is greatly to be regretted that these gentlemen cannot devote their whole time to the duties of their chairs, and the hope is entertained that circumstances may so arrange themselves that this most desirable change may take place sooner than is now in expectation. At the present time the greatest need of the school is for an endowed

department of pathology. The professor of pathology should not practice medicine for a living. His whole time and abilities should be given to pathological work and teaching, and he should receive a sufficient salary to provide for the needs of himself and his family. We have been soliciting contributions rather vaguely for an endowment fund; let us now concentrate our efforts and our beneficences definitely for the establishment of an endowed department of pathology. By a recent legacy the Faculty of Physic will soon come into possession of $5000. This should be devoted specifically to this purpose, and should form the nucleus of an endowment of the pathological department. We therefore ask our alumni and friends to help us to raise $100,000 for this special purpose.

A NEW YEAR.

The editor cannot start into a new year without thanking those who have made the existence of THE BULLETIN possible for six years—contributors, subscribers and advertisers. It is the editor's earnest desire that THE BULLETIN measure up to the expectations of its readers, and has endeavored to make it a first-class medical publication. This is only possible by the loyal support of our alumni, and can only be brought about by those interested in the success of the publication occasionally sending us an article, a news item or by subscribing. Considering that we are in existence to give an outlet to the work of our alumni, and solicit papers from no other source, our paper certainly occupies an unique position, as the pages of most journals are open to the profession in general. THE BULLETIN has steadily improved in tone and quality of articles published, and is performing extremely satisfactorily the object of its creation, namely, the drawing of the alumni into closer bonds of sympathy and the creation of an outlet for the work done in the University Hospital and by our alumni in general, no matter where located.

ABSTRACTS

THE TREATMENT OF ACUTE MANIA.

Charles P. Noble, M.D., Sc.D., class of 1884, of Philadelphia, in a paper on the above subject, *Medical Record,* says he wishes to present to the profession a new treatment of acute mania, based upon a theory of functional insanity, the nature of which he believes he has worked out. This is that functional insanity, so called, is due to the degeneration of the protoplasm of the cortex cells, and of those of the pituitary ganglion, which degeneration he has called molecular degeneration—as it is the degeneration of the units, or the elements, of which the cells are made up, as shown by the difference in the reaction to staining agents in these cells as compared with normal cells.

The process whereby the molecular degeneration is produced is that of autointoxication, together with hypesecretion of pituitary and of thyroid extracts. The intoxication is the result of the increased metabolism brought about by hyperthyroidism. The thought is relatively aberrant and unvolitional, and the will is relatively exalted and is not under the control of the individual; he has, relatively, lost self-control, or, in other words, the power of inhibition.

It has been found that the principle and process are the same in both neurasthenia and in acute functional insanity. It is a question of degree, and not of kind. The irritation stage of neurasthenia may be termed chronic unvolitional irritability, or chronic involuntary anger. Mania is the same thing, exaggerated "an hundred fold." Anger is the obverse of righteous indignation; that is, the one is immoral and the other is moral. It is a disorder of the will, or the spirit, or the soul of man. The irritation stage of neurasthenia consists of unvolitional chronic irritation, or chronic anger. It manifests itself when the individual is acting, or doing, in outbursts of irritability, or of anger, which is relatively beyond the individual's control—relatively, he has lost the power of self-control, and his thought is aberrant, in that in the irritation stage he is optimistic and in the stage of depression he is pessimistic, although he is rational.

When the course of living—the environment—which has caused the neurasthenia is persisted in, the degeneration of the cells becomes progressive, and their function becomes more and more morbid. The reserve vital force in the cells is more and more exhausted, and the potential energy has about all become actual.

If now the individual continues to force himself to do his work, the overworked, degenerated and exhausted cells react violently, and there is an explosion, called mania.

The vicious circle consists of the following:

Of too much work, increased metabolism, chronic autointoxication, irritability and relative exhaustion of the will; increased secretion of pituitary extract, increased secretion of thyroidin, followed by increased and aberrant thought, and progressively increasing autointoxication.

The form of treatment which he has to suggest is that when mania first develops, the subject shall be given a hypodermic of morphine sulphate—about one-third of a grain, repeated if necessary. This will temporarily quiet the patient, when he should be anesthetized with nitrous-oxide gas and oxygen. If this is administered properly, the subject can be kept asleep without risk for an indefinite period. The colon should now be filled with, approximately, three quarts of normal salt solution, and at the same time hypodermoclysis should be employed—filling the subcutaneous connective tissues with, approximately, two quarts of normal salt solution.

If a suitable apparatus is employed, using three Y-tubes, four needles can be inserted at one time, and in this way the salt solution can be administered very promptly.

This process can be repeated from time to time, as the condition of the patient indicates. There can be no objection to the refilling of the colon every eight hours, and at first the hypodermoclysis may be employed once daily. After two or three days it is probably better to intermit the employment of the hypodermoclysis, lest pressure necrosis of the connective tissues ensue.

The patient should be kept in a drowsy condition, or else asleep, by means of the administration of hypnotics—sulphonal, trional, the bromides, morphine, hyoscine, etc.

The object of the treatment is to break the vicious circle—to put the will in abeyance, whereby no nerve force shall be set free in the pituitary gland, and cause the secretion of the extract, and thus in turn, as this extract shall fail to stimulate the thyroid gland, thyrodin will not be produced, and thus in turn it will fail to reach the cells in the cortex of the brain, and thus the aberration of the thought so characteristic of acute mania will not be produced, and hence this thought, this judgment, or this form of nerve force will not set free that form of nerve activity which is called the will; hence the will will no longer be accelerated, but, on the contrary, as the patient should be kept in a drowsy condition, or else actually asleep, he will be will-less.

If this treatment shall be kept up for several days the kidneys will be enabled to get rid of the accumulated toxins, and the patient will therefore become rational. The condition of acute mania will have been reduced to the period of convalescence from the irritation stage of neurasthenia.

It is not the author's purpose in this communication to supply the data in his possession. It is his desire to present this method of treatment to those who are engaged in treating the insane, in order that they may try it for themselves. He states that the form of treatment, if used with reasonable discretion, is without inherent danger.

BRIEF SUMMARY OF ARSENIC TREATMENT OF SYPHILIS ANTEDATING THE MODERN EHRLICH-HATA 606.

In a paper on the above subject by Professor Dr. med. Edward Ehlers, Copenhagen, and translated by Dr. Ejnar Hansen, class of 1904, of New York (*American Medicine*) we glean the following:

Dourine is the name of a disease in horses. For many years it has been the opinion of veterinary surgeons that it was a kind of "horse-syphilis," or a disease very closely related to syphilis.

Dourine (mal du coit, Beschäls krankheit) is a chronic infectious disease attacking horses, donkeys and mules, and only communicated by coitus. It is now rarely found in Europe, all animals suffering from it being immediately killed or castrated. It was first recognized in Tripoli, Algeria, Arabia and Persia; a few cases can also be found in Hungary. In the United States it is sometimes found in Illinois, Nebraska, Wyoming and Dakota. Cases have also been found in the East Indies.

Rouget first found the parasite in 1894, Doflein (Jena 1901) gave to it the name "*trypanosoma equiperdum.*" The disease has three distinct stages.

I. Eleven to twenty days after coitus edema starts around the lower edges of the preputium, it spreads to scrotum, inguinal region and often to the abdominal wall. It is cold and indolent. The temperature is 97 to 97.5°. In a few days this edema will disappear, but the animal is weak and it has difficulty in carrying its rider.

II. (*Eruption*) 40 to 45 days after coitus there will be found on the sides and back infiltrated spots varying in size from a quarter of a dollar

to the size of the palm of the hand. It feels as though a flat piece of metal was imbedded underneath the skin. These spots last from 1 to 10 days. The horse becomes thinner, the hind legs lame, the joints soft, and large, swollen glands can be found in the inguinal region.

III. (*Anemia and paraplegia*). The horse is very lame and has no appetite. Abscesses form which are very difficult to heal. There is conjunctivitis, ulcerative keratitis, distinct crepitus in joints; the bones are easily fractured. At last there is paraplegia and the horse dies. The length of the disease varies from 2 to 10 months.

Treatment gives little result, but several authors praise arsenic as being of some benefit. (Trelut, Archawgelsky, Novikoff, Blaise,) Marchal (veterinary surgeon Constantine 1903) cured five horses suffering from dourine by injecting sodium cacodylate 1 gram dissolved in 4 cc. of water every day for five days, then omitting five days, and so on until the horses were cured. Dourine can be induced in dogs, rabbits, rats and mice by inoculation. Experiments on these animals showed that atoxyl had a specific effect on the disease.

Atoxyl (Ehrlich 1907) was discovered 1863 by a chemist in Montpellier by name Bechamp. Dr. Thomas, an English physician used atoxyl (1904) for sleeping sickness.

Uhlenhut, assisted by Hybener and Woithe from Kaiserlich gesundheitsamt in the winter of 1906-1907, experimenting on rats, mice and rabbits inoculated with dourine, showed that atoxyl could cure the disease even in its worst form.

Schaudinn, who discovered spirocheta pallida, experimented on owls, and in his last work, printed shortly before his death, gave us the theory that trypanosoma and spirocheta are only different steps in the evolution of the same endoglobular hematozooa.

This theory of Schaudinn started Uhlenhut experimenting with atoxyl on a typical spirocheta disease, the so-called chicken spirillosis. His results were surprising. Atoxyl made the parasites disappear from the blood current in 8 to 12 hours, and the sick chicken became lively and well. Injection in other chickens made them immune. These experiments were continued by Hoffman in his atoxyl treatment of apes.

Lesser in Berlin began treating human beings with atoxyl. At the same time similar experiments were made elsewhere by Neisser, Salmon, Hallopeau and Metchnikoff.

Hoffmann's and Weidanz's experiments on rabbits proved that atoxyl had a remarkable effect on syphilis. Rabbits inoculated with syphilis in the eyes and at the same time treated with atoxyl did not develop keratitis syphiliticus. Other rabbits with the same disease were entirely cured by the same treatment. Atoxyl did not, at that time, play any important role in the treatment of syphilis in human beings, because so large a dose was necessary that the patients were exposed to the well-known optic neuritis that claimed so many victims as a result of the atoxyl treatment of sleeping sickness.

Uhlenhut and Manteuffel then tried a combination of arsenic and mercury, but this preparation has as yet not proved very popular. The severe optic atoxyl-neuritis has kept the syphilologist away from this very interesting combination which, when tried on animals, proved to be of much more value than atoxyl.

Rosenthal made some experiments with acidum arsenicosum with satisfactory results. He tried it in 60 cases and used the following solution:

Acidi arseniosi centigram 8.

Acoin 12.

Aqua destill gram 40.

From the above solution he injected one line (Pravaz) every third day, increasing the dose one line until the maximum dose of eight lines. He mentions one very severe case of syphilis of the roof of the mouth and the lower jaw, where the patient could not tolerate mercury. The case was cured with 0.544 gram of above solution injected during five weeks.

Ehrlich has been more successful with his new preparation "606." According to the patent it is derived from atoxyl, but differs from it in name and chemical combination.

It is a well-known fact that Ehrlich reformed our ideas of the chemical combination of atoxyl. It is he who first recognized it as *paramino-phenylarsinacid,* and from this discovery he synthetically reached "606." *Dioxy-diamido-arseno-benzol-dichlorhydraic.*

In this combination arsenic is trivalent, and Ehrlich tells us that the pentavalent arsenic combinations have less value than the trivalent ("606" and arsenophenylglycin.) It is a question if Ehrlich is right. The three most interesting pentavalent arsanilacids are:

Atoxyl.—Paraminophenyl arsinite of Sodium 24% Arsen.

Hektin.—Benzo-sulphonparaminophenyl arsinite of Sodium 19% Arsen.

Arsacetin.—Paracetylaminophenyl arsinite of Sodium 22.3% Arsen.

The bad effect on the optic nerve has brought distrust to Uhlenhut's atoxyl and arsacetin. That leaves us hektin. Hektin was discovered by Moneyrath, professor in chemistry at the University of Lyon. He is known as an associate of Armand Gauthier, who first introduced *Arrhenal* into the modern therapy. In 1904, when he wrote *"L'Arsenique organique,"* he showed us that the step from Arrhenal (Methylarsin Sodium) to atoxyl was not a great one.

After three years of experiments with these combinations on apes and rabbits inoculated with syphilis, hektin entered the syphilitic therapeutic field through Balzer and Hallopeau. Moneyrath thinks that the poisonous effect and curative action of these arsenil compounds is increased by the weight of the aromatic nucleus.

The aminoradical NH_2 in the arsanilates increases the action of the aromatic arsinacid in such a way that the therapeutic dose is smaller than the toxic.

The amin-group (NH_2) can be replaced by hydroxyl with the same result. Two years ago Moneyrath produced several of these combinations and published his methods in *Bulletin francais*, 30 juli 1908. He was the first to produce hydroxyaminophenylarsinacid, which is the compound Ehrlich reduced and by which he gained his dioxyamidoarsenobenzol. Ehrlich was the first to use arsenic combinations in therapy, and knowing that acetanilid was less poisonous and better borne than anilin, he introduced the acetyl-atoxyl-arsacetin.

Moneyrath went another way. He tried to discover how the organism rendered benzol and anilin innocuous when introduced into the blood. He found that when a large dose is injected into the veins of a mammal, a part of it is disposed of unchanged, the other part is oxidized in such a way that benzol is converted into phenol (C_6H_6 to C_6H_5OH), anilin to paraminophenol (C_6H_4-OH_2).

While phenol is not thus rendered actually harmless and still remains as poisonous as benzol, we have the action of the glycuronic acid (COH [CHOH] 4 COOH) and potassium bisulphate combined with phenolhydroxyl forming the less poisonous potassium, phenol and aminophenyl-sulphates and glycuronates.

To counteract the injurious action of the acids (benzoic acid and gallic acid) the organism uses the aminoforming action of the glycocoll and forms amides like hippuric acid.

Moneyrath was chiefly interested in the sulphones uramides, urinary constituents, and after experiments on animals he decided that *hektin* and its mercury salt *hektargyrum* were the best. Hektin plays the same role in the therapy as benzoashydrarg, oxycyan mercury and other soluble mercury salts, and for that reason can be used to better advantage than "606," which coagulates albumin. For the same reason it produces hardly any pain, there is no redness, infiltration or induration and it is not necessary for the patient to stay in bed.

Hallopeau and Balzer (chief surgeons at St. Louis Hospital in Paris), Milan (Paris), Moniz de Aragua (Brazil), advise fractional doses of hektin, 10 centigram daily or 20 centigram every second day until 2-3 gram has been injected. If complications set in, the injection can be stopped at once.

Balzer in a large number of cases has only observed three cases of incipient amblyopia, which disappeared as soon as the injections were stopped. The injections can be made intramuscular, but also locally around the induration, the indolent glands, gummata or tertiary ulcerations. Hallopeau recommends the use of hektin in the manner as above described.

We now know that all attempts to destroy the chancre by cauterization or excision in order to stop the spread of the infection in the system have been futile, because the spirocheta immediately invades the lymph-channels from the place of infection. Hallopeau's method of injecting hektin around the initial lesion seems to open the way to new victories over syphilis. Where the spirocheta can enter, hektin can also enter. Evidence gathered by the above-named men, all well known to syphilologists all over the world, show that when hektin is injected early enough around the chancre, and the lymphangitis or indolent adenitis, it will stop the development of the secondary symptoms. Hallopeau has observed a patient cured by hektin who acquired a fresh infection.

It must be remembered that all arsenic combinations are vasodilators, so hektin should not be used when there is arteriosclerosis. Balzer advises against the use of hektin where the patient suffers from disease of the retina or nervous opticus.

I have been corresponding with Professor Ehl-

ers in regard to hektin, and he tells me that he has used the remedy in about 56-60 cases, is very well satisfied with it and considers it slow, but also a remedy to be depended upon. It is better adapted to office use than "606," the injections are painless and it can be injected as it is received in ampules, without any extraordinary preparations or mixing. It is made by the Hektin Company in Paris, and no doubt any physician can obtain it, either directly or through some reputable drug house.

LABORATORY REPORT OF UNIVERSITY HOSPITAL.

February 1st to 28th, inclusive.

BLOOD EXAMINATIONS.

Leucocyte counts	191	
Erythrocyte counts	16	
Differential Leucocyte counts	7	
Hemoglobin determinations	98	
Smears for Malarial Parasites	12	
Widal Tests	11	
Wasserman Tests	20	
Blood Cultures	10	
Coagulation time	4	
		369

URINE EXAMINATIONS.

Routine Urinalysis		412
(This included chemical tests for Albumin, Bile, Blood, Widal, etc., and in a great many the total estimation for Albumin and Urea. In every case a microscopical examination was made.)		

MISCELLANEOUS.

Gastric Contents—		
Chemical-Microscopical Examination	11	
Feces—		
Macroscopical, Microscopical, and in some cases Chemical Examination	17	
Sputum Examination	26	
Bacteriological Cultures and Smears	15	
Examination of Spinal Fluid	4	
Sections of tissues for Microscopical Examination	30	
Autopsies	2	
		105
Total		886

DR. J. L. HIRSH,
DR. H. J. MALDIES,
DR. R. DILLER.

ITEMS

Dr. Max Kunstler, class of 1907, has purchased the house 2701 Eastern avenue, where he will make his home.

In a letter from Dr. Joseph Angelo Devlin, class of 1906, of 168 W. 87th street, New York, we read:

"Enclosed please find report of a case occurring in my private practice. Perhaps it will be of sufficient interest to publish in THE BULLETIN. I hope you can read my writing, but I shan't blame you if you fail, because I can hardly read it myself sometimes.

"'Bill' Hala of 1905 and yours truly are attempting to preserve the health and deplete the pocketbooks of the people of the West Side, so you will forgive me if I say good-bye and get back to the fray.

"Sincere regards to all who remember me."

Dr. W. Cuthbert Lyon, class of 1907, who has resigned his commission in the United States Army Medical Corps, owing to ill-health, has returned to Baltimore, and in the near future will open an office in one of the suburbs.

At the meeting of the Faculty of Physic, held on March 7, the matter of raising funds for the Department of Pathology was earnestly considered, and the following gentlemen were appointed a committee for this purpose: Profs. Randolph Winslow, John C. Hemmeter, Arthur M. Shipley.

Prof. Randolph Winslow has been appointed by the Provost a member of the Committee on Relations with St. John's; Drs. Hemmeter, Ashby and Mitchell members of a Committee on Trustees.

Dr. Joaquin S. Miranda, class of 1908, is Medical Inspector to the City Health Department of Santiago, Cuba.

Dr. John G. Hollyday, class of 1868, has been compelled to go to Florida, owing to ill-health.

Dr. Houston Boyd Hyatt, class of 1907, of North Carolina, is a patient at the University Hospital.

Mr. G. Y. Massenburg, class of 1911, has been

appointed one of the resident physicians at the Church Home and Infirmary. Dr. Massenburg won this distinction by competitive examination.

Mr. Richard C. Dodson, class of 1911, has been appointed assistant resident physician at the Hebrew Hospital for the coming year.

Dr. Robert Parke Bay, class of 1905, has been selected by Adjutant-General Warfield of the Maryland National Guard as one of the men whose names were submitted to the War Department to observe the maneuvers of the army now mobilized in Texas.

Messrs. Joseph Enloe Thomas, Paul Pressly McCain, Herbert Augustus Codington, William Clinton Marett, and Grafton Dent Townshend, all of the present senior class, have through competitive examination been appointed resident physicians at Bayview Hospital.

Dr. William D. Cawley, class of 1902, of Elkton, Md., is a member of the medical staff of the Union Hospital in Cecil county. His services will be given during the months of March and August, 1911, and January and June, 1912.

Among the consultants at the Union Hospital in Cecil county are the following University graduates: Drs. Randolph Winslow, class of 1873; St. Clair Spruill, class of 1890; Robert L. Mitchell, class of 1905, and Alexander D. McConachie, class of 1890, all of Baltimore, and Dr. Granville Hampton Richards, class of 1908, of Port Deposit. Drs. Winslow, Spruill and Richards are consulting surgeons, Dr. Mitchell assistant consulting gynecologist, and Dr. McConachie consultant on ear, eye and throat diseases.

Dr. Robert Parke Bay, class of 1905, has been appointed lecturer on oral surgery in the department of dentistry of the University of Maryland.

Dr. Louis Hamilton Seth, class of 1908, was a recent visitor in the University Hospital.

Dr. Josiah Slicer Bowen of Mount Washington, class of 1903, read a paper entitled "A Biographical Sketch of Dr. William G. Bodie," at the regular meeting of the Baltimore County Medical Association, held at the Guild House, Towson, March 15, 1911.

Dr. Norman T. Kirk, class of 1910, assistant resident physician in the University Hospital, who recently had his tonsils removed, is sufficiently recovered to resume his duties at the hospital.

Dr. Summerfield Bond, class of 1883, is a patient at the University Hospital.

We are glad to report that Dr. St. Clair Spruill, class of 1890, who has been quite ill, has so far improved as to be able to resume his practice.

We are glad to report that Mr. William Clinton Marett, class of 1911, who has been a patient in the University Hospital, has returned to his studies much improved.

Dr. Erasmus Helm Kloman, class of 1910, assistant resident gynecologist, is a patient in the University Hospital.

Dr. Benjamin Franklin Tefft, Jr., of Anthony, R. I., class of 1905, read a paper on "Sepsis" at the regular monthly meeting of the Kent County (R. I.) Medical Society, held at Arctic, R. I., on February 9. Dr. Tefft is medical examiner for the first district of Kent county.

The Red Springs (N. C.) *Citizen* publishes a portrait of Dr. Roscoe Drake McMillan, and gives an account of the McMillan Sanitarium, which was opened in Red Springs on January 15th of this year by Drs. R. D. McMillan, class of 1909, Benjamin F. McMillan, class of 1882, and John Luther McMillan, class of 1881. The *Citizen* says:

"The present sanitarium, which is located in the Grantham building, is provided with ten rooms for patients; an operating-room and a laboratory for pathological work are features of the institution, the former being equipped with the most modern appliances known to scientific surgery, and the latter having every facility for the examination of the blood for disease germs. Dr. R. D. McMillan, the resident surgeon, received his diploma in 1909, when he was appointed assistant resident surgeon in charge of the Maternity Hospital connected with the University of Maryland, which position afforded a splendid opportunity for the development of both skill and knowledge in the practice of both medicine and surgery amidst conditions and under

circumstances that tested ability. Last year, after serving one year in this capacity, he returned to his home and took up the practice of medicine among the people of his town. Drs. B. F. and J. L. McMillan are graduates of the same university and have been practicing here for many years. Mrs. Mattie Smith, the superintendent of the sanitarium, is a graduate nurse of the Morgantown State Hospital, at Morgantown, N. C., and has served in the Watts Hospital at Durham and at the A. C. L. Hospital at Rocky Mount, N. C.

"It is proposed to erect a three-story building along the railroad tracks for the treatment of white patients and to use a building already erected for colored people, while the building now in use will be devoted to the use of Indian patients. This will give this entire section hospital facilities second to none in the State, and operated by a corps of physicians and surgeons who have the confidence and esteem of the entire community, the direct reward of their pronounced skill and knowledge and of the integrity that characterizes all their relations in both a professional and civic capacity."

Dr. John C. Hemmeter, class of 1884, delivered the annual oration at the meeting of the Pennsylvania Branch of the University of Maryland Alumni Association, held in Harrisburg, February 23, 1911.

Dr. Daniel St. Thomas Jenifer, class of 1904, formerly of Atlantic City, N. J., has removed to Towson, where he will engage in practice.

Dr. Richard C. Massenburg, of Towson, class of 1884, has entirely recovered from his recent illness.

Dr. Josephus A. Wright, class of 1881, assistant superintendent of the Eudowood Sanatorium for Consumptives, has resigned and will practice in Towson.

Dr. Samuel Claggett Chew, class of 1858, was re-elected president of the board of trustees of the Peabody Institute at the meeting held February 13th.

Dr. Howard J. Maldies, class of 1903, has been made lecturer on pathology and bacteriology in the Department of Dentistry of the University.

Dr. George W. Dobbin, class of 1894, has been awarded $3,800 damages for injuries received in an automobile collision.

Dr. Willard James Riddick, class of 1905, assistant surgeon, U. S. N., has been detached from the South Carolina and ordered to the naval station at Guantanamo, Cuba.

DEATHS

Dr. George William Mahle, class of 1905, died at his home, 1903 West Baltimore street, February 20, 1911, of tuberculosis. Dr. Mahle was 29 years of age. After his graduation he became resident physician at Bayview, and resigned one year later to become a surgeon in the Robert Garrett Hospital, which position he held until his death. Dr. Mahle was very popular among the University men, and his death is deeply regretted. He had been seriously ill about two weeks. He is survived by his mother, one brother and four sisters.

Dr. David Marshall Devilbiss of Woodville, Frederick county, Md., died at his home February 14, 1911, from nephritis, aged 66 years. Dr. Devilbiss has practiced in Frederick county since his graduation. He was born near Liberty, Md., April 3, 1845, the son of Adam Washington and Rosanna Devilbiss, both natives of Maryland. His ancestors were Huguenots who fled from France during the French Revolution and found refuge in Germany, afterwards coming to America. Dr, Devilbiss obtained his earlier education at Little Hill Academy and Dickinson College. His preceptor in medicine was Dr. Thomas W. Simpson of Liberty, and he entered the medical department of the University of Maryland in 1870, graduating in 1872. He practiced first at Liberty, then for a year at Adamstown, then returned to Liberty, formed a partnership with his preceptor, Dr. Simpson, and continued in such relationship for seven years. In 1881 he located at Woodbine, where he has since remained. He has served as health officer of Frederick county and as State Senator from Frederick. He was a member of the Medical and Chirurgical Faculty of Maryland and the Frederick County Medical Society. Dr. Devilbiss married Miss L. M. Clary. He is survived by his widow and three children, Marguerite T., Edna C. and Roger M. Devilbiss.

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A PATHFINDER IN THE ETIOLOGY AND PROPHYLAXIS OF YELLOW FEVER,

HENRY R. CARTER, M.D., LL.D.,

SURGEON UNITED STATES PUBLIC HEALTH AND MARINE HOSPITAL SERVICE.

By JOHN C. HEMMETER, M.D., PHIL.D., LL.D.,
Professor of Physiology, University of Maryland,
and
NATHAN WINSLOW, B.A., M.D.,
Associate in Surgery, University of Maryland.

Goethe once classified the various kinds of nature contemplation in a comprehensive way: (1) The lowest grade is represented by the "*Nutzen suchenden,*" the utility-seekers who apply that which nature offers for their utilitarian purposes. (2) The second are the "Wissbegierigen," or those simply eager for knowledge—the "curious for nature." (3) The third are the "Auschauenden," who seek to avoid imagination as far as possible and reduce everything to intuition (from the Latin "*intueri,*" to look on or into). (4) The fourth group are die "Umfassenden"; these minds operate in the opposite manner from the "intuitionalist," for they start from preconceived ideas and seek to encompass (umfassen) their problem by a seeking of a realization of their own ideas in nature.

This classification is a helpful one in endeavoring to understand great minds like that of H. R. Carter.

The discovery of the transmission of the discovery of yellow fever has been credited, and justly so, to the work of Lazear, Reed and Carroll, the latter a member of the class of 1891 of the Medical Department of the University of Maryland. These men, it is true, carried out the experiments which ultimately led to the detection of the manner of conveyance by which yellow fever is communicated from one individual to another. No fair-minded man can deny this fact, but one name which is closely linked to this epochal discovery has been singularly overlooked —that of Henry R. Carter, class of 1879. His work was no less important than that of the three above mentioned. Therefore we gladly tender this tribute with the view of placing on permanent record the exact part played by Carter in the investigation of yellow fever.

Dr. Henry R. Carter is a native of Virginia; attended the University of Virginia three years; studied medicine at the University of Maryland, taking the degree of Doctor of Medicine therein in 1879. He entered the United States Marine Hospital Service the same year, in which he has served ever since, mainly in sanitary work, especially in connection with yellow fever. On June 1, 1910, his Alma Mater bestowed on him the degree of Doctor of Laws.

This honorary degree was bestowed for reasons that will be set forth in the following.

The work on which he looks back with most satisfaction is:

I. The establishment in quarantine practice of the correct relation between the disinfection (fumigation) of vessels and the detention of their personnel for yellow fever.

In the Regulations of the United States Gulf Quarantine Station of 1888, formulated by him, the detention of the personnel of the vessel, to cover the period of incubation of yellow fever, was first dated from the completion of the disinfection (fumigation by sulphur) of the vessel, their last chance of exposure and infection.

At that time the ports of the United States which required fumigation of vessels for yellow fever dated the period of detention "—— days from date of arrival in quarantine," or "from date of departure from last infected port," the number of days varying from "three" to "forty" or "to after frost." But in no case did this period bear any relation to the date of freeing the vessel from infection. It not infrequently happened, then,

HENRY R. CARTER, M.D.

that a vessel would lie her full time—say 20 days—in quarantine and be freed from infection (fumigated) only the day of leaving. Some members of the crew exposed to infection just preceding or during this process in the hold or other seldom-visited parts of the ship would contract yellow fever and develop it after the vessel had docked and they had gone ashore, the period of incubation—five or six days—from the time the fever was contracted being sufficient to allow of this.

This principle is entirely obvious and is the pivot of the whole system of combined disinfection and detention, yet it was ignored not only by United States ports, but in all the British ports considered infectable by yellow fever—Gibraltar, Malta, Jamaica, Trinidad, *et al.*—as well as the French and Danish West Indies, and it was not until the United States Quarantine Regulations became mandatory that it became universal in the United States.

II. Devising a system of maritime quarantine by which such sanitary measures, prevention of infection or disinfection, are taken for vessels in a foreign infected port as will enable them to sail free from infection for the United States from such ports, these measures being rendered possible by corresponding privileges granted at the port of entry to the vessels which adopt them.

This was begun in principle in 1890 and applied extensively in 1893 at the cholera-infected ports of Europe. It is now an integral part of Maritime Quarantine System of the United States, and has been of great value both as a purely sanitary measure and as removing restrictions to commerce, especially the last.

III. Work on the epidemiology of yellow fever, including the determination of its period of incubation in man, and especially the discovery of the "extrinsic incubation" of that disease.

Dr. Henry R. Carter showed that while the existence of a case of yellow fever in an infectable environment can render that environment infect-*ed* in a very short time, a few hours, yet a considerable period of time must elapse before that environment becomes infect-*ive*—that is, capable of communicating yellow fever to other men. This Dr. Carter called the "extrinsic incubation of yellow fever," and fixed its period at "somewhat over 10 days as a minimum." This is in close analogy with the time as determined by Celli and others that elapses between the date of an anopheles mosquito becoming infected with the parasite of malaria and becoming capable of conveying that disease. This fact was used with much advantage in epidemiological work in 1898 and 1899. The genius of Reed, James Carroll and Lazear (it was Lazear who first spoke to Dr. Carter of its implying a living host) used this thesis as a clue to the problem of the conveyance of yellow fever. It is this that gives it its especial importance, and it is no small gratification to Dr. Carter to think that his work assisted in the epoch-making discovery of Carroll and Reed.

IV. In addition to the above permanent work of enduring excellence, presumably we should call attention to Dr. Carter's work in the yellow-fever epidemics of 1893, 1897, 1898 and 1899, the details of which are on record in the United States Public Health and Marine Hospital Service. In these epidemics he represented the United States; in Louisiana only in 1897; in the entire infected area in 1898 and 1899. This was purely executive work, and was done with practically no authority, "in co-operation with State and local health authorities." Yet it was adjudged to have been successful. In his districts commerce was carried on fairly well, panic was quieted, and there was no spread of fever to new sections. In 1898, working with the Mississippi health authorities, the epidemic of yellow fever at McHenry, a town in Southern Mississippi, was suppressed. This was the first instance of an epidemic of yellow fever in the far South, well under way, in June and July, being suppressed.

The method used was the control of the human host. The conveyance by the stegomyia was *not* then known, and, except the unnecessary disinfection of clothing, was not all adapted to that end, even in the modern light of the mosquito conveyance. The same methods here instituted were used successfully by White and Von Ezdorf in an outbreak of yellow fever at Hampton, Va., two years later.

We have contrasted this executive work with permanent original or research work. This class of executive work bears the same relation to, say, the determination of the extrinsic incubation of yellow fever that a campaign, the troops using firearms, does to the discovery of gunpowder. The strategist avails himself of what the investigator discovers.

As an estimate of the value of Dr. Carter's work the following letters are appended:

Board of Health Laboratory,
Ancon, Canal Zone, October 4, 1909.
Dr. William Royal Stokes,
City Hall Annex,
Baltimore, Md.

Dear Dr. Stokes:

Before I forget it again I must write to you about a matter that has been on my mind for several months. Dr. H. R. Carter, who was our first Chief Quarantine Officer, and for four and one-half years Director of Hospitals here, has returned to the States, to be located at Louisville, Ky.

Dr. Carter, as you know, by his wonderfully keen observations made during several epidemics of yellow fever, particularly the one in Louisiana, brought out his theory of an "extrinsic period of incubation," which was of the greatest value in helping Reed to a successful issue in his yellow-fever experiments.

Ronald Ross told me in Liverpool three years ago that he had put in Dr. Carter's name for the Nobel prize. Dr. Carter has never received quite the recognition he deserves for his yellow-fever observations and for his pioneer quarantine work.

As you and he are alumni of the University of Maryland, I want to suggest that you use your influence in getting an honorary degree from the University for him next year. I cannot see why he has been neglected, for his work is recognized abroad and in all literature on the subject, and his name will always be linked with Finlay's in connection with yellow fever.

Reed in letters to Dr. Carter told him how valuable Dr. Carter's observations had been to him in his yellow-fever work.

I sent some slides showing malarial zygotes and sporozotes to Dr. Pearce of Winnipeg, and hope they were of some value to him.

With kindest regards to Mrs. Stokes and the children, I am,

Yours very truly,
S. T. DARLING.

I have also made the suggestion to Dr. Perry, our present quarantine officer, about the honorary degree for Dr. Carter.

Board of Health Laboratory,
Ancon, Canal Zone, December 1, 1909.
Dr. William Royal Stokes,
City Hall Annex,
Baltimore, Md.

Dear Dr. Stokes:

I have received from the members of Dr. Carter's family data relating to his work, investigations and published researches in compliance with your request of October 14.

1st. *The determination of the period of incubation of yellow fever:*

The determination of the period of incubation of yellow fever in man and the placing of the period of quarantine detention of the personnel for this disease on a rational basis, dating it from their last exposure. The completion of disinfection to cover the period of incubation, while all ports of the United States and Great Britain were dating it from the hour of arrival in quarantine to leaving the infected port, the period of this detention being apparently chosen arbitrarily, as no two ports had the same. The disinfection of vessels on leaving ports infected with yellow fever and dating the time of detention from this disinfection so that the days *en route* would count as days in quarantine. This, of course, he applied to all vessels leaving ports where quarantinable diseases carried by vessels prevailed.

2d. *The discovery that there was a period of "Extrinsic Incubation" in its environment for yellow fever and the approximate determination of its minimum duration as somewhat over* 10 *days:*

By "extrinsic incubation" was meant that a certain considerable period of time must elapse between the date that a place received infection from a yellow-fever patient before it became infective, *i. e.,* capable of conveying it to other men. These investigations were begun in 1888. The article was written in December, 1899, and January, 1900, and published in May, 1900. He himself, however, had been using it as a working basis for several years before—no one else accepting it.

3d. *Quarantine work at Chandeleur and Ship Island in* 1888 *to* 1892:

What was really done at Ship Island and Chandeleur was the establishment of the United States Maritime Quarantine System and the systematization of the quarantine methods for yellow fever. Prior to this time the State quarantine stations of the South Atlantic and Gulf ports differed among themselves in regulations, methods of disinfection and period of incubation, and no one station was willing to take the pratique of the other. His effort at Ship Island was to get them all to agree upon one method of handling vessels, doing all that was necessary and nothing that was believed to be unnecessary. That was successful, and before he left the Southern ports accepted the pratique of the United States stations.

It was while here that he formulated his ideas of disinfecting vessels at the port of departure so that the days *en route* should count as days in quarantine. This was proposed at the meeting of the American Public Health Association at Charleston, S. C., in 1890. It was regarded as impracticable by some and dangerous by others, but is now universally accepted by sanitarians and is the key to practically all the methods of the United States quarantine. Its benefits to commerce can readily be imagined. It was also here, while working upon the problem of the incubation of yellow fever in man, that he discovered the phenomenon of the "extrinsic incubation" of that disease in infected places, which he subsequently

worked out in 1898. Prior to this time, however, he was sufficiently convinced of its truth to use it as a working basis.

Since leaving Ship Island and Chandeleur he has held every quarantine station of the United States from Ship Island to Delaware Breakwater, and had much to do with founding and equipping them. He had charge of the train inspection, communication and everything save measures in the city in the Brunswick epidemic of yellow fever in 1893. He was in charge of the measures in Louisiana and the train inspection in the epidemic of 1897. He was in charge of the South in the epidemics of 1898 and 1899. In 1898 he was in charge of the epidemic of yellow fever in the little town of McHenry, Miss., which was, it is believed, the first place in the South in which an epidemic of yellow fever had ever been stamped out in the summer time. He organized and had charge of the quarantine of the Island of Cuba in 1899-1900.

SOME OF HIS PUBLISHED RESEARCHES.

1st. "A Note on the Interval Between Infecting and Secondary Cases of Yellow Fever from the Records of Yellow Fever at Orwood and Taylor, Miss., 1898."—*The New Orleans Medical and Surgical Journal, May,* 1900.

2d. "A Note on the Spread of Yellow Fever in Houses—the 'Extrinsic Incubation.'"—*Medical Record, June* 15, 1901.

This was written for the medical convention that met at Havana February, 1901.

3d. "A Correlation of Some Facts in the propagation of Yellow Fever, with the Theory of Its Conveyance by the *Culex fasciatus.*"—*Philadelphia Medical Journal, April* 6, 1901.

This was written while he was sick in hospital in Baltimore in November, 1900.

4th. "Are Vessels Infected with Yellow Fever? Some Personal Observations."—*Medical Record, March* 22, 1902.

5th. "Some Characteristics of the *Stegomyia fasciatus* which Affect Its Conveyance of Yellow Fever."—*Medical Record, May* 14, 1904.

6th. "The Conveyance of Yellow Fever."—*Medical News, November* 5, 1904.

Read before the Texas State Medical Association April 27, 1904.

7th. A little memorandum written April 6, 1906; published in the *Medical Record*—date not known—aiming to show that yellow fever was habitually contracted in the daytime, at least in Panama, in contravention of the statement of Marchanx, Simon and Salimbini.

Besides this, there have been a number of articles written for publication by the service, giving in detail the measures necessary in handling yellow-fever epidemics—*i. e.,* train inspection, communications with a town infected with yellow fever, etc. There have been, also, articles on other professional subjects, the first one in 1882, entitled "Syphilis in the Negro."

RECENT PAPERS.

"Recent Advances in Tropical Medicine." Read before the Pan-American Scientific Congress held at Santiago, Chili, December 25, 1908, to January 5, 1909.

"Malarial Fever Work on the Isthmus." Read before the Canal Zone Medical Association in 1908.

In 1905 or 1906 Dr. Carter's name was presented for the Nobel prize in medicine. At that time he prepared a statement of his relations to the study of yellow fever as a sanitarian and an epidemiologist. The substance of Dr. Carter's statement is outlined above. There is no doubt that Dr. Carter's researches induced Durham and Walter Meyer to make the yellow-fever investigation at Pará, and that it actually influenced (and as to time determined) the direction of Reed's investigations as well is borne out by many verbal and written statements by him. Dr. Reed had been much impressed by the valuable observations made at Orwood and Taylor, Miss., by Dr. Carter on the interval between infecting and secondary cases of yellow fever. Experiments by Dr. Reed confirmed those already mentioned by Dr. Carter in 1898 that at least 12 days must elapse between contamination of the mosquito by the blood of a yellow-fever patient and the communication of the disease. Ronald Ross regarded Dr. Carter's observations on the extrinsic period of incubation of yellow fever as an extremely important one in its relation to the work of the Yellow Fever Commission in Cuba. Dr. Ross has recently invited Dr. Carter to contribute a chapter on his forthcoming book on tropical hygiene.

The above memoranda expresses in bare outlines Dr. Carter's work in connection with yellow fever, sanitation and quarantine.

Very truly yours,

S. T. DARLING.

Baltimore, Md.

Dr. John C. Hemmeter:

Dear Doctor—A number of the friends of Dr. H. R. Carter have thought for some time that it would be a deserving honor for him if his Alma Mater, the University of Maryland, could confer an honorary degree upon him on account of the early and important work which he carried out and which led directly to the brilliant discoveries of Reed and of his assistants concerning the transmission of yellow fever by the mosquito. I am informed by Dr. S. T. Darling, who has charge of the hygienic laboratory of the Canal Zone, that Dr. Carter has left the Isthmus and is about to settle in Louisville. Dr. Darling has very carefully collected the data which we enclose, and I think that you will agree that this work is deserving of proper recognition. On the other hand, it adds to the glory of our Alma Mater to emphasize such humanitarian work when performed by one of her sons. We therefore respectfully ex-

press the wish and hope that you will attempt to secure an honorary degree for Dr. Carter.

The following is the data collected by Dr. Darling concerning the work, investigations and published researches in compliance with your request of October 14:

1st. *The determination of the period of incubation of yellow fever:*

The determination of the period of incubation of yellow fever in man and the placing of the period of quarantine detention of the personnel for this disease on a rational basis, dating it from their last exposure. The completion of disinfection to cover the period of incubation, while all ports of the United States and Great Britain were dating it from the hour of arrival in quarantine to leaving the infected port, the period of this detention being apparently chosen arbitrarily, as no two ports have the same. The disinfection of vessels on leaving ports infected with yellow fever and dating the time of detention from this disinfection so that the days *en route* would count as days in quarantine. This, of course, he applied to all vessels leaving ports where quarantinable diseases carried by vessels prevailed.

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"Recent Advances in Tropical Medicine." Read before the Pan-American Scientific Congress, held at Santiago, Chili, December 25, 1908, to January 5, 1909.

"Malarial Fever Work on the Isthmus." Read before the Canal Zone Medical Association, 1908.

In 1905 or 1906 Dr. Carter's name was presented for the Nobel prize in medicine. At that time he prepared a statement of his relations to the study of yellow fever as a sanitarian and epidemiologist. The substance of Dr. Carter's statement is outlined above. There is no doubt that Dr. Carter's researches induced Durham and Walter Meyer to make the yellow-fever investigation at Pára, and that it actually influenced (and as to time determined) the direction of Reed's investigations, as will be borne out by many verbal and written statements by him. Dr. Reed had been impressed by the valuable observations made at Orwood and Taylor, Miss., by Dr. Carter on the interval between infecting and secondary cases of yellow fever. Experiments by Dr. Reed confirmed those already mentioned by Dr. Carter in 1898 that at least 12 days must elapse between the contamination of the mosquito by the blood of the yellow-fever patient and the communication of the disease. Ronald Ross regarded Dr. Carter's observation on the extrinsic period of incubation of yellow fever as an extremely important one in its relation to the work of the Yellow Fever Commission in Cuba. Dr. Ross has recently invited Dr. Carter to contribute a chapter on his forthcoming book on tropical hygiene.

The above memoranda expresses in bare outlines Dr. Carter's work in connection with yellow fever, sanitation and quarantine.

Yours very truly,

WILLIAM ROYAL STOKES.

CONCLUSION.

We have now reached a sufficient degree of familiarity with Carter's work and the method of his research and thinking to recognize that he belongs to Goethe's "*Auschauenden.*" He is clearly an objective worker who seeks to avoid imagination as far as possible, and humbly submits to the hard facts of observation and experiment.

The day will come when some great thinker—a medical Bancroft—will write the history of American medicine, and then such pioneers and heroes as James Carroll and Henry R. Carter will stand out on the roll of honor in the American Medical "*Walhalla*" as brilliant as the names of any scientists, artists, statesmen, naval or military heroes our nation has ever produced. And this is to let the world know that they are sons of the University of Maryland.

A CASE OF PERSISTENT VOMITING FOLLOWING GASTRO-ENTEROSTOMY, PERFORMED FIVE YEARS AGO—SECOND ABDOMINAL SECTION, DECEMBER, 1910—CHEMIC AND PHYSIOLOGIC STUDY OF DISTURBED CO-ORDINATION BETWEEN THE STOMACH AND DUODENUM.

Reported and shown by

ALBERT H. CARROLL, M.D.; E. E. NICHOLS, *Senior Medical Student, and* W. C. MARETT, *Senior Medical Student in Prof. John C. Hemmeter's Clinic on Diseases of Digestion and Metabolism, University of Maryland.*

This interesting case which we have to present today is one of those obstinate cases of vomiting, with quantities of bile in the vomita, with emaciation, anemia and with marked nervous symptoms. An atrophic pancreatic condition was at first suspected and carefully looked for. The findings were negative.

We are now convinced that this is a case of what is commonly called "vicious circle," following a gastro-enterostomy. This operation was done five years ago. It appears to us that relief will only be had by undoing the work then done, and this has been recommended.

Entrance note. History.

Name, C. E.; age, 30 years; occupation, fireman on steamship of Hamburg-American line; social condition, single.

The patient entered this hospital December 5, 1910, complaining of stomach trouble. He first had trouble with his stomach eight years ago, when he had severe fullness and "hardness" after eating, with frequent vomiting. He was treated for two years; his stomach was washed out every night. Six years ago—two years after his trouble began—he was operated on in Hamburg, Germany, by Professor Urban. At that time a gastro-enterostomy was done. Fourteen days ago he noticed a sensation of burning and heaviness in the

epigastric region, coming on about one hour after taking food. This was relieved either by vomiting (which was frequent) or disappeared in about two hours. For the first six or seven days he kept on working, but since then he has been confined to bed.

The vomitus is "lime-green" in color. Before this operation was performed the patient "vomited blood" twice. His appetite is poor; the bowels are regular. The first six days' stools were black and tar-like. No history of jaundice.

Examination for occult blood was not made till later, and was not found then.

Habits.—Patient worked five years in a brewery in Germany, during which time he drank beer in large quantities. A history of other dietary indiscretions or of trauma at any time was not obtained. We must remember that he is a stoker.

Family History.—Father died in 1880 in Australia. Mother living and well; one sister and one brother living and well. Negative to cancer, tuberculosis, gout, epilepsy, etc.

Past History.—Negative to diphtheria, tuberculosis, measles, scarlet fever, rheumatism, pneumonia and pleurisy. Had typhoid lasting six weeks while in Argentina, S. A., two years ago. He had an attack of gonorrhea at the age of 20 years which lasted nine months, and again at 28 years of age, which lasted five weeks. Past history otherwise negative, except such troubles as above described.

Present Illness.—While at work about two weeks ago he was taken with pains of a dragging, dull character in his epigastrium, followed by sour eructations of a burning character and by vomiting. He says that the vomitus was largely composed of mucus of a whitish-gray color. Since then he has had numerous cramps—like attacks which were followed by the vomiting of a greenish substance. Owing to poor digestion and assimilation, he is weak and has lost weight. He is very downcast and discouraged.

Physical Examination.—The patient is a fairly well-developed white man, with muscles of fair tone. The head is round, and is covered with a good crop of light hair. Forehead receding; no scars. Ears, no tophi, mastoid tenderness or discharge. Nose, no discharge or tenderness over accessory sinuses. Eyes, pupils equal and react to light and accommodation, conjunctiva somewhat injected, sclera clear, ocular movement good. Mouth, teeth in bad state of preservation, pyorrhea marked. Tongue protrudes in the median line, slight tremor. Dorsum fairly clear, breath foul. No tonsillar enlargement. Neck well developed, post-cervical glands palpable. No abnormal pulsations or tracheal tug. Thyroid gland not palpable.

Chest.—Fairly well developed, palpation and percussion normal and equal. Auscultation, voice sounds are decreased on the left side.

Heart.—P. M. I. neither visible nor palpable. Sounds at apex beat heard at fifth interspace, to the inner side of M. C. L., of good tone and quality. No murmurs were heard; absolute cardiac dullness is not increased.

Abdomen.—Liver dullness begins at seventh rib, and palpable two fingers' breadth below costal margin. A median post-operative scar is noted above the umbilicus; it is about three inches in length.

Stomach.—Extends to the umbilicus, and gurgling sounds were heard on direct percussion, otherwise negative. Inguinal glands palpable.

Genitalia.—Large, bilateral varicocele. No scar.

Extremities.—Poorly developed. His reflexes are normal. The axillary and epitrochlear glands are palpable. Pulse regular, tension and volume fair, and rhythm good.

This case was referred from the medical to the surgical side, and an exploratory laparotomy advised. The abdomen was opened by Dr. J. Holmes Smith, and it was found that a gastro-enterostomy had been performed. The stomach was opened, and both the pyloric and the artificial opening found patent. No evidence of a past or present ulcer was present, or at least not observed. A large intestinal loop had been used. No obstruction was found, and the openings in the stomach and in the abdomen were closed in the usual way.

The patient's condition at first led us to suspect an atrophic pancreatis. (Later findings negate this diagnosis.)

It has been noted that gastro-enterostomies are frequently followed by an atrophy of the pancreas. (The normal stimulation of the pancreas is due in part to the action of the acid gastric contents on the papilla of Vater. This is supposed to send a reflex stimulation to the pancreas and excite it to action.)

There are but few physical symptoms or signs by which a positive diagnosis of atrophy of the pancreas can be made. The pancreas is not normally a palpable organ. Small cubes of boiled

meat enclosed in gauze were fed to this patient. The nucleii were not found in the muscle fibers when the gauze bags were examined after they had passed through the alimentary tract. Pancreatis is associated with a great deal of weakness, emaciation and epigastric pain. Stools did not contain fat in excess after a diet of olive oil and milk.

Urine.—Color, amber; odor, aromatic. Reaction acid, spgr. 1020. Albumen and sugar, absent; sediment, few epithelial cells and some granular.

Stomach Contents.—On December 7 the patient vomited, and vomitus showed bile present in large amount. Free HCl 8. Total acidity 20. No blood. On December 8, after a test meal, the stomach contents were drawn, and consisted of about one pint of greenish fluid, with a fine brownish sediment. Free HCl absent Total acidity 36. Again no blood was found. Lactic acid test was negative. Microscopical examination—yeast cells, muscle fibers, cellulose and fat present, bile present. Blood, leucocytes 12,600, reds 3,500,000.

Medicinal Treatment.—Had a pancreatitis really complicated this case of "vicious circle," we might have given artificial preparations of the pancreas, pancreatin or papain to replace the pancreatic ferments. However, we doubt the presence of an atrophic pancreatis, basing our diagnosis on the microscopical examination of the feces after a fat plus a meat diet.

His measurements are as follows:

M. X., 8 inches.
M. U., 16 inches.
M. S., 8½ inches.
X. R. S., 9 inches.
X. L. S., 9 inches.
S. S., 9 inches.
C. at X., 34 inches.
A. at X., 90°.
Height, 5½ feet.
X angle, 90°.
Weight, 125 pounds.
Age, 30 years.
Present clinical findings:
Hemoglobin, 70°.
Urine, negative to albumen and sugar.
Feces, no starch or an excess of fat.
Stomach contents, no free HCl; total acidity, 30; no blood.
Sputum negative to T. B.

No gastroptosis, and only a slight dilation of the stomach.

No floating tenth ribs.

No occult blood found.

Treatment.—This is surgical. The gastro-enterostomy should be undone and the opening between stomach and duodenum should be closed. The food will then pass through the pylorus into the duodenum, and thereby restore the normal stimulus to the pancreas. Although there was a deficiency of HCl, an undiscovered ulcer is to be thought of, and the return flow of alkaline intestinal secretions may have neutralized any hyperacidity.

The prognosis is not favorable.

The patient has returned to Germany.

CARCINOMA OF SCALP.*

By A. Aldridge Matthews, M.D.,
Spokane, Wash.

Case VIII.—A. K., schoolboy; age 14. Referred to me October 24, 1910.

Past and family history negative. In February of this year he was struck on the head with a dress-suit case, the corner of which lacerated his head in the post-parietal region on the left side. He went to a physician, who cleaned the wound and sewed it up. The wound healed by first intention and seemed to be practically well, but about two months later he noticed a small swelling about the size of a bean, which he thought was a wart starting on his head. He went back to his physician, who excised a little growth, and told him that it would give him no more trouble. A little later, after the wound had healed, he noticed that the growth was coming back, and he let it grow until it reached the size of half a hen's egg, as he expressed it. At this time he went to another physician, who removed this growth again and sutured the wound together, which healed primarily, this being only six weeks ago. Since this time the growth has increased very rapidly in size and is now the size you see it, about three inches in diameter and one inch in thickness. It occupies the post-parietal and occipital region on the left side. It is very hard and firm to the touch, and painless.

The glands down the neck are palpable, the largest being about the size of the end of your

*Reported at Spokane County Medical Society.

finger. I removed one of these glands and had it examined, and found it to be a carcinoma. This, I must say, I felt skeptical about. From the clinical history I made my diagnosis a sarcoma, but the involving of these glands made it puzzling.

A day or two after my examination I operated upon this boy, removing a large area of scalp around the growth, also removing the periosteum, and had contemplated removing the bone, but upon removing the periosteum I found that there was no apparent direct connection between the

CASE 8. A. K.

Above picture represents about three-quarters of the original size of growth and a vertical scar from a previous operation and stitch-hole scars on the sides.

growth and the bone, except that it was a little more adherent in the area where I think he received the original blow, and from that area I removed a piece of bone about the size of a half dollar, although there is a question in my mind whether it was involved. I also made a dissection of the glands of the neck.

In closing the incision I had to slip flaps from three directions, covering over the area of the bone from which I had removed the periosteum. These flaps were composed of the scalp, but did not disturb the periosteum under them, simply using the flaps alone to cover the bone. The wound healed up primarily, and on the eighth day following the operation I grafted skin on the periosteum, from which I had removed my sliding flaps. I would have done this at the time of the operation, but there was so much capillary oozing that I was certain the grafts would not take. The grafts I got from his thigh.

The young man up to the present time has been perfectly well and no indication of any recurrence. This specimen is the growth which I removed, but is very much shrunken from the preservative solution it has been kept in. Sections made from the growth proved the diagnosis to be carcinoma.

REPORT OF A CASE OF SARCOMA OF TIBIA.*

By A. Aldridge Matthews, M.D.,
Spokane, Wash.

Case XII.—N. M. L., schoolgirl; age 15.

I was called in consultation to see above patient with Dr. J. F. Hall of Spokane. Family history negative. Past history negative. Present trouble dates back about nine months, and at this time she claims that her little sister kicked her on the upper third and anterior surface of right tibia. She thought nothing of it at the time, but it remained sore all the time upon pressure, and also complained that after using her leg she felt a little soreness in that region. About three months ago a small swelling appeared over this area which had been tender for so long, which was quite hard to the feel and gave her pain upon pressure.

About six months after receiving the injury she went to see a physician, who told her that he thought there was possibly some pus in this area and suggested opening it, but she declined, and after letting it go for some time went to see another physician, this being about six weeks ago, who advised opening down upon this small swelling, as he thought there was some pus present. This was done with local anesthesia, but after so doing he advised her that he could do nothing without putting her to sleep and scraping it out.

At present the growth presents a large red swelling of the inner upper third of the tibia;

*Reported at Spokane County Medical Society.

hard, quite sensitive to pressure, and now causes her considerable trouble when she walks. This discomfort in walking is gradually getting worse. The incision, which was done six weeks ago, had perfectly healed, but the growth had increased considerable in size in that time.

I agreed with Dr. Hall in his diagnosis as this being an osteosarcoma, and advised immediate amputation. On the next day, the 28th of November, I operated. Before amputating I opened down upon the growth, and felt convinced without a reasonable doubt that it was an osteosarcoma; the variety I could not say positively, as I had no means at that time for making sections. I then amputated a short way above the condyles of the femur, this giving me ample flaps to cover the stump. The patient did perfectly well, but the flaps underwent a dry gangrene for no reason as far as I can see. The blood supply seemed to have been ample, although she bled very little at the time of amputation.

CASE 12. M. M. L.
Osteo-sarcoma of upper third of tibia.

There was no infection at any time in the wound, not even 10 days after the work was done, and about this time I placed the patient under an anesthetic, trimmed off the dried back flaps, resected about two inches of the femur, and drew my new flaps over, which healed primarily.

This is my second experience in having flaps slough after amputating for sarcoma. I cannot give any reason why this should be, although I have had other men tell me that they have had the same experience.

I placed this patient on Coley serum and gave her increased doses for six weeks following the amputation. The patient is well and in excellent condition at present date.

TREATMENT OF PUERPERAL ECLAMPSIA.*

By Roscoe D. McMillan, M.D., '10,
Red Springs, N. C.

In presenting this paper I fully realize that I have chosen a subject whose very depths stand as yet unsounded, as we all know eclampsia is one of the most formidable accidents to which the pregnant woman is liable. This subject, like many other questions of medical interest, the older they are the more they are subjected to discussion and to criticism, the more interesting they become, especially in these late years when they can be approached and studied, and in some instances solved by scientific methods of investigation, yet this disease is still classed as "The Disease of Theories." In order to treat any disease successfully, it is very necessary that the doctor have a thorough understanding of the cause or causes of the disease he is about to treat, but as yet we are absolutely ignorant concerning the cause of this dreaded malady, but we know that there is a toxic substance circulating in the blood which should have been, but has not been, eliminated by the various excretory organs.

The treatment may be divided into two heads, namely, prohpylactic and curative.

First, Prophylaxis.—This, if instituted at the proper time, will prevent many cases of eclampsia, and is certainly productive of untold good, but is not always successful or applicable. It is a very unfortunate thing that the doctor rarely sees the

*Read before Fifth District Medical Society of North Carolina October 11, 1910, at Fayetteville, N. C.

case until he is called, and the woman is found in labor or in active convulsions.

In every case where the doctor has the opportunity he should forcibly impress his patient, as well as her husband, the paramount importance of the proper care of the pregnant woman; a specimen of urine should be sent to his office regularly twice a month for the first seven months, and once a week during the last two months of pregnancy, and he should be promptly advised if any of the characteristic symptoms arise as disturbance of vision, continued headache, edema of face and limbs and scanty urine. Where there is any reason at all to suspect trouble the physician should see the patient himself and institute at once proper treatment. Restrict the diet principally to milk, with the addition of dry toast, fruits, chicken broths and the use of plenty of good drinking water. Avoid all stimulants, tea, coffee and meats. Keep the skin, liver and kidneys in active condition. Watch your patient closely for a few days, and if she does not improve under this expectant treatment don't delay, but empty the uterus in the most conservative manner by the induction of premature labor. By the use of these precautionary measures the frequency of eclampsia will be greatly diminished, and many valuable lives saved.

Curative.—When in the presence of actual convulsions, each and every case should be treated rationally, the treatment being determined upon and directed against the cause or causes as they present themselves in the individual case, but I strongly advise against the use of chloroform in the hope of cutting the convulsive seizures short. In this case morphia is the sheet anchor. Give a hypodermic of morphia grs. ¼, combined with atrophia grs. 1-150 every 30 minutes until four or five doses are given. It is remarkable the immunity these patients seem to enjoy against the evil effects of this drug. A folded towel should be placed between the patient's teeth to prevent biting her tongue. Stimulate diuresis and bowel movements, and for this I know of nothing better than the old and time-honored drug powdered calomel given in large doses, 15 to 20 grains, on back of tongue. If the convulsions come on during pregnancy or labor, deliver your patient as soon as possible. As Williams says, "delivery should be effected as soon as is consistent with the safety of the patient," and I heartily agree with him. If the head is low down, deliver with forceps; if high, it is well to resort to internal podalic version. Of course, either should be done under profound anesthesia and rigid asepsis, and ether is the anesthetic of choice. Where the cervical canal is obliterated, or nearly so, the dilation can be completed by the Harris method of finger dilatation, or with the aid of instrumental dilatation, using instruments with caution. If the canal has not been obliterated, and is very resistant, don't hesitate, but cut the cervix with blunt scissors and empty the uterus.

After delivery of the child the eliminative organs should be encouraged as much as possible. If the bowels have not moved, give two drops of croton oil in one dram of olive oil on back of tongue. Surround patient with hot packs, blankets wrung in hot water, and surround with hot-water bottles.

Diuresis and diaphoresis should be encouraged, and I strongly advise against the use of salt solution and the hypodermic injection of pilocarpine. If there is excessive nervousness, give 30 grains of chloral and 30 grains of potassium bromide in a pint of hot water passed high into the rectum.

In the class of cases with high arterial tension, the withdrawal of several ounces of blood from the arm or a lumbar puncture is sometimes attended with happy results.

My experience with Veratrum Viridi in this class of cases is sufficient to condemn its use, especially in private practice.

A very important fact to remember is that in a great majority of cases the heart muscle is weak, and the treatment all along has been of a depressant nature; the fact must not be lost sight of that stimulation may be necessary. No treatment should ever be pushed to the point of endangering the patient's life from heart failure.

In conclusion, will say the entire line of treatment can be summed up in one word, namely, elimination, and in every case where delivery has not been accomplished, it is well to hasten delivery by all practical means, as the condition of pregnancy is the cause of causes.

Dr. Rigdon Osmond Dees, class of 1906, is pursuing special work at the University. Dr. Dees and his brother, Ralph Erastus Dees, also of the class of 1906, are located at Greensboro, N. C., and enjoy extensive practices.

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MD., APRIL 15, 1911.

THE RANDOLPH WINSLOW SCHOLARSHIP.

Another scholarship has been founded for the benefit of needy and worthy students of the Medical Department of the University of Maryland. This makes four scholarships now available in our school for this purpose: The Samuel Leon Frank scholarships, endowed by the widow of the late Dr. Samuel Leon Frank; the two Hitchcock scholarship, created through a bequest of the late Dr. Charles M. Hitchcock of California, and the Randolph Winslow scholarship, endowed by Prof. Randolph Winslow. This bequest has been completed and becomes available next October. It is not intended to assist idle and incompetent students, but only those who are both needy and worthy. It is open to students of the senior, junior or sophomore classes who are of good character and who are in need of assistance to continue their studies and who have maintained an average grade of 85 per cent. in all their previous work. The scholarship is to be awarded by the Trustees of the Endowment Fund upon the nomination of the Faculty of Physic.

THE ENDOWMENT OF THE DEPARTMENT OF PATHOLOGY.

Elsewhere will be found an appeal from the committee on endowment to the alumni and others for aid in raising $100,000 to place our pathological department upon a full time paid basis. This is the most urgent need of the medical school at this time. The committee is working upon this problem. The public will be asked to help us in this matter, but the individual classes that have gone from our threshold each year are also solicited to make contributions as classes, and, where it is possible, a member of each class for the past forty years will be appointed to communicate with his classmates and solicit their cooperation in this purpose. Some headway has already been made in this campaign, and several alumni have promised substantial contributions. The Faculty of Physic will devote the bequest of the late Miss Robinson to this fund.

Robinson bequest	$5000
Class of 1873—Dr. T. A. Ashby, Dr. R. Winslow	200
Class of 1882—Dr. J. M. Hundley	250
Class of 1901—Dr. Nathan Winslow	50
Class of 1902—Dr. A. M. Shipley	250
	$5750

ABSTRACTS

DEFECTIVE CHILDREN.

Dr. Watson Smith Rankin, class of 1901, in an address before the North Carolina Teachers' Assembly, Asheville, N. C., June 17, 1910, has the following to say concerning adenoids in an article entitled "The Importance of the Recognition of Physically Defective Children by the Teacher" (*Bulletin of the North Carolina Board of Health*, October, 1910):

"*Adenoids.*—They are composed of what we call lymphoid tissue, the principal function of which is to act as a filter or sieve to catch invading germs. Its structure is admirably adapted to its function; it consists of only two parts; small, very small threads or fibers of tissue running in all directions and interlacing so as to form a structure like nothing so much as a spider's web. In the meshes of this web is the second part, namely, millions of very small, round cells. Into this meshwork of fibers and cells a fluid which is known as lymph is poured, and the lymph is the fluid that has exuded from the blood vessels into the tissues which it has nourished and is being returned to the veins. However, in nourishing the tissues the lymph takes up the waste products of the tissue cells and any germs that happen to be in the tissues. It is, therefore, important that before this fluid, the lymph, be poured into the veins, thence into the heart, and then sent to all parts of the body, that it be filtered; and so it is passed through this lymphoid filter, where any germs it may carry

are inmeshed in the fibers and destroyed by the little round cells.

"Nature has wisely placed this filter tissue in those situations where filtration of the lymph is most needed; that is, in those places where germs are most abundant and most likely to gain entrance into the tissues or flesh. Hence we find large accumulations of lymphoid masses, lymph glands, in the armpits, where they guard the body against the entrance of germs that get into the flesh of the upper extremity; we find many of these lymph glands in the groins, guarding the body against infection from the lower extremity; the intestine is full of germs, and the intestinal tube has an abundance of this filter tissue in its walls, and so, in proportion to the exposure of any locality of the body to infection, do we find lymphoid tissue in varying amounts. Again, as the child has had less training in fighting germs than the adult, and is more prone to disease than the adult, less able to protect itself, so it needs relatively more of this lymphoid tissue than the adult, and it is a fact that lymphoid tissue is relatively more abundant under 12 than after that age, when, not needed so much, it undergoes considerable shrinkage.

"Now, of all places exposed to infection or germs, the tube through which we consume our gaseous food, the tube through which we breathe, is most exposed. Unlike the tube through which we take our liquid and solid food, it is in constant use. In breathing air of average purity we inhale about 25,000 germs per minute; most of those germs are, fortunately, harmless. Through this portal enter the germs causing tuberculosis, pneumonia, scarlet fever, measles, whooping-cough and other diseases. Tuberculosis and pneumonia, the two greatest causes of death, kill 300,000 people a year, one-fifth of the entire death rate of the United States. The most exposed portion of this most exposed tube is an angle in the tube just back of the nose, where the horizontal or nasal part of the tube joins the vertical or pharyngeal part of the tube. Now, dust and germs tend, by the laws of gravity, to lodge in this angle of the breathing tube. And Nature, following the rule of providing most of this lymphoid or filter tissue where exposure is greatest, has abundantly supplied the roof of the throat which is at the back of the nose; that is, the angle of the breathing tube, with this tissue.

"With these two factors, a large amount of soft, spongy tissue and constant and comparatively severe exposure to irritation, we may be on our guard for trouble in the pharyngeal vault. As long as the lymphoid tissue can take care of the germs gaining entrance there is no trouble. But in about 10 per cent. of children this becomes impossible, and these lymphoid masses swell. If the trouble is soon removed, the swelling subsides and no permanent damage results. On the other hand, should the irritation be unusual in amount or of long duration, a permanent enlargement, varying in size from a hazelnut to a hen's egg, results; and this is what we call adenoids. These enlarged masses of tissue are lobulated, soft, and feel to a finger pushed into the throat like a mass of earth worms, bleed very easily, and are covered over with a layer of thick mucus which is often mixed with pus or matter.

"The first effect of this nasal obstruction, naturally, is to interfere with the breathing. The child is obliged to have air, and, being unable to get it through the nose, becomes a 'mouth breather.' If the postnasal obstruction is not too great, the child during waking hours will, by extra muscular effort and by keeping the nose and throat clear of mucus, be able to get in enough air through the nose; but at night, when these voluntary processes are in abeyance, the child uses both nose and mouth, and this means snoring. It means, as a rule, disturbed sleep, too. The small amount of oxygen gives to the subconscious mind an uneasy feeling, producing bad dreams which awaken the child with 'night terrors.' As the masses of adenoid tissue grow or become inflamed, mouth breathing becomes more and more a vital necessity, until the child breathes day and night through the open mouth. Now, with the nose partially or completely discarded as a respiratory tube, and the mouth having taken up this work, it becomes necessary that the mouth cavity be enlarged. This enlargement takes place by the roof of the mouth bulging upward into the now useless nasal cavity. This bend having once started, the constant inward pressure of the strong muscles of mastication accentuates it, causing the high-vaulted palate, the narrow dental arch with its forward protrusion and crowded teeth. These factors combined give us the characteristic adenoid expression: the narrow face, the undeveloped, small nostrils, the short upper lip, the absence of normal lines about the mouth, the narrow nose, the drooping inner angle of the eyes, and the high-arched eyebrows.

"The voice loses that quality given it by an open pharyngeal vault—resonance. The speech is stuffy; F is substituted for T H, so that 'teeth' is pronounced 'teef;' G is substituted for N G, so that 'song' is pronounced 'sogg;' B is substituted for M, and D for N, so that 'common' is pronounced 'cobbed,' and 'nose' is pronounced 'dose.'

"Breathing is greatly interfered with, quantitatively and qualitatively. The *quantity* of air admitted is diminished in proportion to the amount of obstruction. If much diminished, there is a partial collapse of the spongy lung tissue. This leaves a vacuum in the chest and the chest walls; the softer part of them along each side of the breastbone become depressed, giving us the chest with the prominent breastbone or pigeon-breast. The *quality* of the inspired air is altered. Normally, the extensive, convoluted and turbinated nasal walls, giving a very extensive warm, moist surface, serve to warm the inspired air and to filter out on their sticky surfaces many of the germs. Not so when nasal respiration is partially or completely abolished. The air entering the lungs is colder, and, carrying more germs, it makes the adenoid victim very susceptible to cold, grip, pneumonia, tuberculosis and other air-borne diseases.

"Smell is to varying extents destroyed. The inflamed and mucus and pus-covered adenoid tissue at the back of the nose grows forward into the unused nasal cavity. The nasal mucous membrane becomes chronically inflamed and covered with mucus and pus. This means that smell, located in this membrane and dependent upon its healthy condition, is to varying degrees destroyed. You probably recall in this connection your own loss of this sense when you suffered from the ordinary nasal cold. Now, the sense of smell and taste are closely related; the sense of taste is two-thirds dependent upon smell. In the brain the centers of smell and taste are next-door neighbors. Recall again the loss of taste in colds. Moreover, taste is an important adjunct to digestion. Appetite, the desire for food, is very dependent upon taste. Science has also demonstrated that the secretion of digestive juices in the stomach is due in part to reflex nervous influences originating in taste. Now, when taste is interfered with the appetite is poor, less food is taken, and on account of the decrease in amount of digestive juice, what is taken is less well digested. Thus, adenoids interfere with the *ingestion* of *all foods,* gases to the lungs, liquids and solids to the stomach, and with the *digestion* of the solids and liquids. The result is a stunted growth and a decrease in the capacity for all kinds of work. * * * The number and distinctiveness of the symptoms vary with the duration and severity of the disease.

"The mild cases sleep poorly, snore, and many of them have 'night terrors.' They are very susceptible to colds and coughs; many are physically and mentally stunted.

"The medium cases have all the symptoms of mild cases accentuated, and mouth breathing is usually present during the day. The characteristic expression, already described, is now easily recognized.

"The severe cases show all the symptoms described in connection with the disease in a pronounced and easily recognizable form."

ITEMS

The following report was submitted to the Alumni Advisory Council at their last meeting, March 23, 1911, by Dr. E. F. Cordell, chairman Committee on Nomenclature:

Having been requested to suggest a nomenclature for the buildings of the University, I present the following: St. John's being adequately provided for in the designations—McDowell Hall, Humphreys Hall, Pinckney Hall, Woodward Hall, Senior or Mess Hall, Gymnasium, etc.—does not require consideration here. I shall confine myself therefore to the professional schools of the University located in Baltimore.

Although the custom of applying the names of eminent presidents, professors, alumni and benefactors to different departments of universities has been adopted elsewhere and is growing in favor and practice, it has only recently been applied in this institution. I may say, however, without offense I hope, that the results have not been so far very satisfactory. Perhaps the matter was not considered sufficiently. It seems exceedingly desirable that a systematic nomenclature should be adopted by the Regents. There are practical as well as sentimental reasons for its consideration and application that must appear convincing to anyone who gives the matter due thought. We are not called on as yet to honor in this way any great benefactor, so that our action must be dictated by sentiment.

1. The Department of Medicine. There is one name that especially appeals to us in this depart-

ment for recognition, and that is John B. Davidge, the founder of the Medical School and the University. To adequately honor him we should associate his name with the main medical building and call it "Davidge Hall." Professor Potter, also a founder and incumbent of the chair of practice for 36 years, certainly comes second, and the building now known as "Davidge Hall" might receive his name. Practice Hall, to which the misnomer Gray Laboratories has been applied, might bear that of De Butts, the eloquent chemist (1809 to 1831), since it contains the chemical laboratory, a department over which he presided with so much reputation and success. The proposed students' dormitory, on the northwest corner of Greene and Lombard streets, might be called "Smith Hall," after the great surgeon, Nathan R. Smith. I would suggest that the names "anatomical theater" and "chemical theater" be retained, since they are so appropriate and have been sanctioned by such long usage. The laboratories do not need any change, and may still be called "The Chemical Laboratory," "The Pathological Laboratory," "The Physiological Laboratory," "The Clinical Laboratory," and the same in the case with "The Dean's Office," "The Students' Room," "The Dissecting Room," "The Library" and "The Christian Association Room."

In the Department of Law there are five names that especially appeal to us, viz., those of Chief Justice Taney, John P. Kennedy and S. Teackle Wallis, who were provosts and men of great eminence; David Hoffman, the first professor of law and founder of the Law School, and John P. Poe, who was so long connected with the reorganized school as professor and dean. It seems eminently appropriate that we should select the greatest of these names to designate the law building, which would thus in future be known as "Taney Hall." There are but two lecture-rooms at this time, so that we are compelled to make a choice of two of the others for these, and I would suggest that they be known henceforth as Wallis and Poe Rooms, respectively. I hope the day is not distant when the other two names shall be commemorated in some way, perhaps by professorships, scholarships, prizes or medals.

In the Department of Dentistry the name of the Father of American Dentistry, Dr. Horace H. Hayden, who delivered in this University in 1837 what was, so far as we know, the first scientific course of lectures given in America, suggests itself, and it would be eminently appropriate that the dental building should receive the name "Hayden Hall." The laboratories and infirmary need no change, but I suggest that the dental museum receive the name of "Gorgas Museum," in honor of the distinguished dean, to whose labors it is due. There should be some commemoration also of the late Prof. James H. Harris, who was associated with Professor Gorgas in the founding of the school and was famed as a skilful dentist, but the future must provide for this want.

The Department of Pharmacy is not at present in need of a nomenclature, but when it gets a building, as it must soon do, to provide for its growing classes, the name of David Stewart, one of its founders and who enjoyed the distinction of being the first independent professor of pharmacy in America, could well be used to designate its "Hall."

I have thus endeavored to fulfil the responsible duty which you imposed upon me at the last meeting. It will be seen that I have adopted the name "Hall" for the various buildings, and "Room" for the apartments of the same, following in this respect what I believe is the common usage. The laboratories suggest their own designations.

All of which is respectfully submitted.

EUGENE F. CORDELL, M.D.,
Committee.

March 21, 1911.

Dr. Reed A. Shankwiler, class of 1909, who was for some time a resident physician at Eudowood Sanitarium, Towson, Md., has been appointed superintendent of the Detroit Tuberculosis Sanitarium, which has been recently erected in Detroit. Dr. Shankwiler is at present the guest of his mother at 3809 Park Heights avenue, Baltimore. He was until very recently connected with the Hazelwood Sanitarium of Louisville, Ky.

The undersigned committee direct the following appeal to our alumni:

Dear Sir—The Faculty of Physics, being firmly convinced that the scientific chairs of a medical school should be filled by scientists who give their whole time to the duties of their chairs, and not by practitioners of medicine, have appointed the subscribers a committee to devise means to bring about this important change in the School of Medicine of the University of Maryland.

We therefore ask the aid of our alumni and

friends in raising the sum of $100,000 for the endowment of the Department of Pathology.

Any amount that you may feel able to contribute to this object will be gratefully received, as will also any suggestions or other assistance that may expedite our purpose.

This fund will be administered by "The Trustees of the Endowment Fund of the University of Maryland," an entirely independent corporation, not connected with the teaching faculties of the University.

Subscriptions may be sent to any of the undersigned, and will be gratefully acknowledged in THE HOSPITAL BULLETIN and in Old Maryland.

Very truly yours,

RANDOLPH WINSLOW,
JOHN C. HEMMETER,
ARTHUR M. SHIPLEY.

Dr. Robert H. Hargrove, class of 1877, is located at Kinston, N. C.

Dr. T. A. Ashby, class of 1873, of Baltimore, has sold to Mr. Arthur L. Warthen, president of the Front Royal (Va.) National Bank, the place known as Belmont, situated about a mile south of Front Royal. The purchase price was $40,000. The tract contains 825 acres, and has long been acknowledged one of the finest fruit farms in Virginia. The vineyards and wine cellars of Belmont had a national reputation when Marcus B. Buck owned and operated them, and it is said that Mr. Buck spent $200,000 in improving the property, which Mr. Warthen will restore to its former beauty. From the elevation of Belmont a view of the Shenandoah Valley for 20 miles may be had. It is understood to be Mr. Warthen's purpose to turn the present house into a handsome colonial residence.

Dr. Arthur B. Clarke, class of 1906, is practicing at Plantersville, S. C.

Miss Lucy B. Squires, class of 1909, University Hospital Training School for Nurses, is located at 226 East Duval street, Jacksonville, Fla.

The editors of THE BULLETIN are very anxious to secure copies of THE BULLETIN for July, 1905; January, 1907, and March, 1908. If any of our readers have copies to spare, they will help us greatly by sending them to complete our files.

Miss Henrietta Gourley, class of 1908, University Hospital Training School for Nurses, who went to Fayetteville, N. C., to accept a position as superintendent of nurses at St. Luke's Hospital, has been compelled to resign owing to ill-health, and she is now with her brother-in-law, Dr. Guy W. Latimer, class of 1901, of Hyattsville, Md. Drs. R. B. Hayes, class of 1906, and T. Marshall West, class of 1908, own the hospital, and are, as Dr. West puts it, "pegging away" very hard toward the success we wish for them. It is likely that Miss Gourley will be succeeded by Miss Kimmel, class of 1910.

The annual commencement of the University will be held June 1, 1911.

We regret to report that our beloved Prof. Samuel C. Chew, class of 1858, is very ill with grippe.

Among the recent visitors to the University Hospital was Dr. Louis Hamilton Seth, class of 1907.

Dr. Aloysis W. Valentine, class of 1904, of 606 N. Carolina avenue S. E., Washington, writes:

"It seems that the Faculty should impress upon each graduate the importance and the value of pushing the school along after they leave it. The Advisory Council is a step in the right direction, but what is wanted is enthusiasm among the men turned out each year. Our hope lies in the recent graduates who are more receptive in catching the University idea. It seems as if the Alumni Association is not active enough in securing new graduates. Cannot something be done to catch them before they leave the shop, so to speak?

"Give my best wishes to the bunch, and save some for Dr. Randolph Winslow."

The members of the class of 1885 are located as follows:

R. L. Allen, Waynesville, N. C.

C. W. Barker, 1116 West Fayette street, Baltimore.

E. M. Beach, West Long Branch, N. J.

Joseph Blum, 1816 Madison avenue, Baltimore.

G. F. Boucsein, Ellinwood, Kans.

Leigh Buckner, 1101 Franklin road, Roanoke, Va.

B. F. Bussey, Texas, Md.
D. G. Caldwell, Concord, N. C.
P. G. Dill, 1433 West Lombard street, Baltimore.
John H. Dorsey, Glencoe, Minn.
R. B. Epting, Greenwood, S. C.
George Y. Everhart, Dickeyville, Md.
Ira L. Fetterhoff, Carrollton and Lafayette avenues, Baltimore.
Geo. M. Fickes, Seven Valleys, Pa.
Alva G. Floyd, Fair Bluff, N. C.
H. E. Gale, 260 West Hoffman street, Baltimore.
Wm. F. Hall, Crisfield, Md.
E. T. W. Hall, Freemansburg, W. Va.
J. T. Hering, 1728 St. Paul street, Baltimore.
N. M. Hendricks, 1601 East 5th street, Dayton, Ohio.
B. M. R. Hopkinson, Professional Building, Baltimore.
J. N. Humrichhouse, Council Bluffs, Iowa.
J. T. B. Hyslop, Bellehaven, Va.
R.E.L. Johnston, 721 E street, Memphis, Tenn.
H. M. Julian, 7732 Virginia avenue, St. Louis, Mo.
Louis C. Carrico, Bryantown, Md.
H. L. Clark, Washington, Pa.
Edw. C. Coleman, Kosciusko, Miss.
John C. Cort, Clairton, Pa.
A. C. Coble, Dauphin, Pa.
H. C. Conley, Boone, Iowa.
I. H. Davis, Charles and Pleasant streets, Baltimore.
C. K. Jump, 1415 Madison avenue, Baltimore.
Geo. C. Kinard, Lincoln, Pa.
J. C. Lemmer, Oil City, Pa.
J. C. Lockbridge, Driscoll, W. Va.
Lewis W. Morris, Salisbury, Md.
V. L. Norwood, 939 West Fayette street, Baltimore.
J. C. Perry, U. S. P. H. and M. H. S., Canal Zone.
S. L. Phillips, 232 Bull street, Savannah, Ga.
W. A. Plecker, Hampton, Va.
John H. Reed, Logansport, Ind.
Howard C. Reamer, Danville, Cal.
W. J. Rivers, Eastover, S. C.
C. W. Sawyer, Elizabeth City, N. C.
Samuel Schwalbe, 6618 Michigan avenue, St. Louis, Mo.
Wm. A. Shoemaker, 1006 Carleton Building, St. Louis, Mo.
M. B. Shupe, Connellsville, Pa.
J. Campbell Smith, 3750 Westminster boulevard, St. Louis, Mo.
G. W. Todd, Salisbury, Md.
H. M. Thomas, 1228 Madison avenue, Baltimore.
E. P. Turner, Ferguson's Wharf, Va.
A. K. Warner, 1056 Belmont avenue, Chicago, Ill.
A. S. Warder, Grafton, W. Va.
John A. Murray, Patton, Pa.
John P. Smallwood, Falls Church, Va.
J. Fletcher Somers, Crisfield, Md.

Of the class three members—Frank Camm, G. Linton Shipp and F. M. Latham—have died, and we are unable to locate the following members: J. B. Carr, J. M. Emmitt, B. B. Halsey, E. K. Hardin, C. H. Janney, H. C. Jamison, D. T. E. Casteel, P. B. Carter, S. B. Dew, A. F. Keen, W. P. Kennedy, E. T. May, C. E. Rogers and W. T. Spruill.

If any of our readers know the present location of any of the above, will they kindly notify us immediately? THE BULLETIN wishes to correctly list each alumnus of the University.

Dr. Herbert Seth Anderton, class of 1910, is the guest of his brother in California.

A campaign for funds will be launched in the near future to endow the department of pathology in the University of Maryland.

Dr. J. Lewis Hanes, class of 1902, is located at Winston-Salem, N. C.

According to the fifty-eighth annual report of the Northeastern Dispensary, 1224-1226 East Monument street, Baltimore, our alumni hold the following positions: Secretary board of directors, Alexander D. McConachie, class of 1890; general medicine, Percy E. Lilly, class of 1901; eye and ear, Alexander D. McConachie, class of 1890, and Josiah Slicer Bowen, class of 1903; gynecology, William S. Smith, class of 1883, and chief of outdoor clinic, Percy E. Lilly, class of 1901.

Dr. A. Aldridge Matthews, class of 1900, of Spokane, Washington, who was for several years superintendent of the University Hospital, has succeeding in building up a very extensive sur-

gical practice in his adopted city. Dr. Matthews is a Marylander by birth. His brother, Dr. James G. Matthews, class of 1905, is associated with him in practice.

We are glad to report that Mr. William L. Byerly, a member of the medical class of 1911, who was operated upon recently for appendicitis, has sufficiently recovered to resume his studies.

The General Alumni Association will tender a smoker and buffet luncheon May 30, 1911, at the Medical and Chirurgical Faculty Building, 1211 Cathedral street, at 8.15 P. M., to the graduating classes of the several departments. This feature was inaugurated last year and will become an annual institution.

Amongst our alumni located in North Carolina are:

ALBEMARLE.

Jasper M. Anderson, class of 1895.
William Isaac Hill, class of 1897.
Virgil A. Whiteley, class of 1884.

ASHBORO.

Houston Boyd Hiatt, class of 1907.

ASHEVILLE.

Charles Collins Orr, class of 1904.
Charles L. Scott, class of 1897.

BAILEY.

S. B. Drew, class of 1885.

BEAUFORT.

Charles L. Duncan, class of 1902.

BETHEL.

Guy F. Thigpen, class of 1903.

BRYSON CITY.

Daniel R. Bryson, class of 1900.

BURGAW.

Peter Prentiss Causey, class of 1897.

BURLINGTON.

Charles Manly Walters, class of 1908.

BUXTON.

Judson J. Davis, class of 1891.

CARTHAGE.

Gilbert McLeod, class of 1882.

CASAR.

Thomas A. Mathews, class of 1890.

CHARLOTTE.

James Ramsey Alexander, class of 1894.
Ephraim M. Brevard, class of 1894.
Andrew Johnson Crowell, class of 1893.
Samuel McKee Crowell, class of 1895.
John E. S. Davidson, class of 1894.
John McC. De Armon, class of 1886.
John Robinson Irwin, class of 1877.
William R. McCain, class of 1897.
Calvin S. McLaughlin, class of 1906.
J. Pleasant Matheson, class of 1905.
Charles H. C. Mills, class of 1897.
Edgar Reid Russell, class of 1895.
Charles Moore Strong, class of 1889.
Charles E. Walker, class of 1891.

CHINA GROVE.

Banks Withers, class of 1896.

CLINTON.

Frank Huske Holmes, class of 1895.

COLERAIN.

Luther A. Nowell, class of 1894.

COLUMBIA.

Joseph L. Spruill, class of 1895.

CONCORD.

Daniel Greenlee Caldwell, class of 1885.
James S. Lafferty, class of 1881.
William David Pemberton, class of 1887.
Francis Owenton Rogers, class of 1901.

COOLEEMEE.

John R. Lowry, class of 1904.

BIRTHS

Dr. Louis Cottin Skinner, class of 1901, and Mrs. Skinner, of Greenville, N. C., are being congratulated upon the birth of a daughter, April 4, 1911, who has been named Elizabeth Minor.

DEATHS

Dr. Adolph Gustav Hoen, class of 1873, died at his home in Waverly, Md., March 29, 1911. Dr. Hoen was born November 28, 1853, of German descent. His father was August Hoen, founder of the lithographic firm of A. Hoen & Co. of Baltimore, and was born at Frankfurt-on-the-Main, Germany. His mother was Caroline V. Muth, and lived to a very advanced age. Dr. Hoen was

educated in a private German school and Loyola College. He afterwards entered the University of Maryland, graduating in 1873. He started to practice in Baltimore, but because of ill-health removed to Burlington, Wis., where he remained for four years, returning to Baltimore in 1878. In 1894 he became identified with the anatomical department of the Johns Hopkins Medical School, having direction of the photo-micrographic laboratory of this department, and continued as a part of the teaching force of the institution until the end of 1897. He then became director of the clinical laboratory of the Suffern Sanitarium of New York State, a branch institution of the Pasteur Institute of New York city, then under the direction of the late Paul Gibier, M.D. In 1900 he became director of the Pasteur Institute of Virginia, located at Richmond, which position he filled until his death. In 1903 he also assumed the directorship of the histological laboratories of the University College of Medicine of Richmond. He was a member of the Medical and Chirurgical Faculty of Maryland, the Virginia State Medical Society and the Academy of Medicine of Richmond. Dr. Hoen married Miss Helen M. Nixdorff, who survives him. He also leaves four children, Messrs. August, Stanley and Ralph Hoen, and one daughter, Ethel—Mrs. Benjamin Hanson, Jr.

BOOK REVIEW

International Clinics. A Quarterly of Illustrated Clinical Lectures and Original Articles. Vol. I, Series 21, 1911. Philadelphia. 1911. $2.00.

Without hesitation we pronounce this probably the most interesting volume of International Clinics yet issued. Its articles are on live subjects of the day—Pellagra in the United States; Treatment of Syphilis by "606;" Poliomyelitis Investigations; Open Treatment of Fractures; Ulceration of the Male Bladder; The Cellular Basis of the Determination of Sex; Mosquito Work in the Canal Zone.

The inclusion of Maryland on the colored map (frontispiece) among Southern States where pellagra is "prevalent" is probably unfair unless her 10 cases came from her own borders; and even then 10 cases of any disease in one year do not justify the label "prevalent." At the same time the attraction of professional attention to this curious disease (now said to be carried not by spoiled corn, but by the sand-flea), which blooms out in the surface tissues of a chronic patient in summer to vanish in winter so completely that among a hundred summer cases scarcely one winter diagnosis can be made (page 2) even by false numerical statements, is pardonable.

Though Baltimore cannot get a sufficient number of cases for one medical demonstration at society meetings, yet there may occur in the practice of any physician obscure cases which baffle detection.

LABORATORY REPORT OF THE UNIVERSITY HOSPITAL.

Month of March.

Blood Examinations.

Leucocyte Counts	158	
Erythrocyte Counts	12	
Differential Leucocyte Counts	6	
Hemoglobin Determinations	102	
Smears for Malarial Parasites	10	
Blood Cultures	2	
Wasserman Tests	25	
		315

Urine Examinations.

Routine Urinalysis (chemical and microscopic)	464	
Total estimation for Urea	23	
Total estimation for Albumen	10	
		497

Miscellaneous.

Gastric Contents (chemical and microscopic)	15	
Feces (macroscopical, microscopical and some cases chemical examination)	9	
Sputum Examination	25	
Bacteriological Cultures and Smears (from operative cases)	37	
Bacteriological Cultures (throat)	120	
Examination of Spinal Fluid	1	
Section of Tissue for Microscopical Examination	33	
Autopsies	3	
		243
Total		1055

Dr. J. L. Hirsh,
Dr. H. J. Maldeis,
Dr. R. Diller.

THE HOSPITAL BULLETIN

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THE WASSERMANN REACTION.

By Herbert Schoenrich, M.D.,
Baltimore, Md.

With the rapid advancement made in the treatment of syphilis, beginning with the more intelligent administration of mercury, potassium iodide and arsenic, followed with the newer compounds of arsenic as arsacetin, atoxyl, arsenophenylglycin, etc., and finally with Prof. Ehrlich's famous remedy, dioxydiamido-arsenobenzol, and taking into consideration the remarkable results obtained, the rapidity in the disappearance of lesions, we are confronted more and more with the serious questions, "Is the patient *cured?* Has he syphilis; if so, to what extent? What are the possibilities of a recovery, of dangerous sequels, etc.? The profession will agree that there is no answer more reliable, more trustworthy, than the result of a Wassermann reaction. Most all hospitals are carrying it out weekly in the laboratories; specialists are employing it in their office, and, in fact, parts of Europe the test has been accepted as a criterion in medico-legal court proceedings.

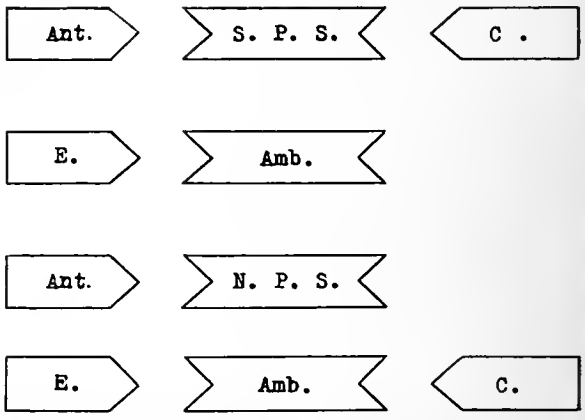
It is not within the scope of this paper to go deeply into all the details of the test, nor to describe the many and varied modifications, but more to give a comprehensive review covering the theory of the Wassermann-Neisser-Bruck reaction and the technic employed. In order to understand this test it is necessary to be informed in regard to the phenomenon of hemolysis, and to know what is meant by the Bordet-Gengue phenomenon. It has been a long-established fact, discovered by Belfanti and Carbone, that an animal of one species acquires a specific lytic power when injected with the washed red corpuscles obtained from an animal of another species. If, for example, you take the washed red corpuscles of a sheep and mix them with the serum of a rabbit in a test tube, there will be no change, and the corpuscles will gravitate to the bottom of the test tube, leaving the clear serum above. If, on the other hand, you immunize the rabbit with sheep's corpuscles, there will be formed in the serum of that rabbit a new body termed *amboceptor,* which, in the presence of *complement* (a constituent of all fresh, normal sera), has the power of bringing into solution erythrocytes. Thus, collect the serum from the immunized rabbit and treat it with sheep's corpuscles, and there will result a complete solution of the latter, and the rabbit is said to be immunized against sheep's blood. This phenomenon is known as *hemolysis,* which means to lake, to render transparent an opaque suspension of blood corpuscles; and substances which cause hemolysis are said to be hemolytic for the blood corpuscles which they dissolve. The laking of blood is due to the immune body (amboceptor) combining with its specific red blood corpuscles in the presence of fresh complement. Substances, when injected into an animal capable of producing amboceptors, are known as *antigens.* Bordet and Gengue showed that in the same manner as specific, immune bodies (hemolytic amboceptor) are produced in animals injected with the blood of another species; by the injection of bacteria or albumanoid substances, immune bodies (amboceptors) are produced in the injected animal which will combine with the specific bacteria or albumanoid substance, respectively, in the presence of complement. In using erythrocytes as an antigen the corresponding amboceptor is known as a hemolytic amboceptor. In the case of bacteria it would be a bacteriolytic amboceptor, and when employing unorganized protein, as egg albumen or alien blood serum, the product formed

in the animal is called *precipitin*. By heating amboceptor for a half hour at 56 degrees centigrade, it will lose its power to dissolve blood corpuscles, and is said to have been rendered "inactivated." Inactivated serum, however, does not correspond to normal serum, for if you add to the former a quantity of normal serum, it will again become activated, repossessing the property of hemolysis. This is explained by the fact that complement is destroyed when heated for a half hour at the temperature of 56 degrees centigrade. Thus, when adding normal serum to inactivated amboceptor, you are adding complement and reactivating the amboceptor. Amboceptor itself is more or less stable, and not easily destroyed by heat, and is said to be *thermostabile*. Complement is destroyed by heat or *thermolabile*. In order, then, to bring about hemolysis, three agents are necessary, namely, antigen, amboceptor and complement, which together constitute a *hemolytic system*. An antibody can show its presence in serum by its power of fixing or taking up complement in a hemolytic system. This phenomenon of disappearance of complement in a mixture of antigen and antibody is known as "fixation (anchoring or binding) of complement," or the Bordet-Gengue phenomenon.

The Wassermann reaction depends upon there being something present (syphilitic antibody) in the serum of the syphilitic patient, which, in the presence of certain lipoid or fatty substance (antigen), has the property of taking up complement, so that upon the addition of hemolytic amboceptor and erythrocytes no hemolysis takes place. This binding of complement is made evident by the fact that when you take syphilitic patients' inactivated serum, and, adding antigen and fresh complement and incubate for an hour at 37½ degrees centigrade (allowing them to unite), that, in spite of of the complement content, there will be no hemolysis by the addition of blood corpuscles and amboceptor. On the other hand, assuming that the patient's serum were normal, *i. e.*, not containing the syphilitic antibody, there would be no complement fixation, and consequently upon the further addition of amboceptor and blood corpuscles, the complement, not having been fixed, would be free to act with the corpuscles, and hemolysis would occur. (See Figure 1.)

Inasmuch as in syphilis it has been impossible to obtain a pure culture of the specific organism, it was necessary to use as antigen an extract of syphilitic tissue known to contain the organism in large quantities. For this purpose extracts were prepared from the livers of syphilitic fetuses, from the fact that livers were very rich in the fatty or lipoid element. Later it was shown, however, that an extract made from normal fetal livers also contained an antigen similar to the one from a syphilitic liver: in fact, it developed further that a variety of normal organs contained an available "antigen," namely, an extract from healthy guinea pigs' heart muscle, from guinea pig livers. Porges and Meier used lecithin as an antigen very successfully. Other lipoid substances which have been experimented with are sodium glycocholate and taurocholate (Levaditi); sodium oleate (Sachs and Altman); oleic acid (Sachs and Rodoni);

FIGURE 1.



Ant.—Antigen. S. P. S.—Syphilitic patient's serum. C.—Complement. E.—Erythrocytes. Amb.—Amboceptor. N. P. S.—Normal patient's serum.

cholesterin and vaseline (Fleishman); sodium cholate (Noguchi).

The reagents necessary to perform the test are five in number, namely, antigen, amboceptor, blood corpuscles, complement and patient's serum.

Antigen.—As has been intimated, one of a variety of antigens may be employed satisfactorily. Noguchi devotes a very interesting chapter to the preparation of antigens in his recent work on "The Serum Diagnosis of Syphilis." I have prepared a satisfactory antigen from normal heart (human) muscle. A quantity of heart muscle is passed through a hashing machine; of this 100 grams are weighed off and placed in a suitable glass jar. Add 500 c. c. of absolute alcohol, close jar tightly, and place it into an incubator for several days, or keep it at a temperature of 60 degrees centigrade for 24 hours. The solution is then

filtered and preserved in a well-stoppered bottle in a dark place. Antigen is fairly stable, and when preserved properly will keep for a year or longer. With antigen prepared as described, a dilution of 1 in 10 will usually suffice; it must be tested, however, from time to time, so as to ascertain that the antigen dilution does not cause complement fixation with normal serum. This is determined by making a series of dilutions of antigen and combining them on the one hand with known syphilitic serum, and on the other hand with normal serum. Note the dilution in which the antigen does not fix complement with normal serum, but does fix with syphilitic serum, and use that in your test. In other words, the strongest solution of antigen is employed that will fix complement with syphilitic sera, but does not fix with normal sera.

Amboceptor.—A healthy medium-sized rabbit is inoculated with the washed corpuscles of a sheep or chicken. The blood must be obtained directly from the blood vessel and collected in a sterile flask containing sterile beads or broken glass, in order to facilitate the breaking up of the clot. After gently shaking the flask for a few minutes the blood is transferred into sterile centrifugal tubes and centrifugalized until the corpuscles are thrown down, leaving the clear serum above, which is replaced with .85 per cent. sterile physiological saline solution. This process of washing of corpuscles in order to rid them from their complement is repeated three or four times. Finally sterile saline solution is added sufficient to make up the original volume of blood employed. The rabbit to be injected is tied down on an animal-holder or held by an assistant. The usual aseptic surgical precautions should be observed, such as scrubbing up the abdomen with soap and water, to be followed with alcohol and a solution of bichloride. Shaving is not always necessary. The blood to be injected is drawn into a sterile syringe provided with a needle of large caliber, which is inserted through the abdominal wall. The needle should be inserted through the muscles of the abdomen very gently and obliquely, and the peritoneum is entered by giving a slight jerk to the syringe perpendicularly. As the point enters the peritoneal cavity the resistance ceases suddenly, and the tip of the needle becomes freely movable among the intestines. The greatest danger to be avoided is the puncturing of the intestines. After a little practice, however, and by lowering the head of the animal, this danger is overcome. The fluid should always be warmed just previous to the injection by placing the beaker containing it in a vessel of hot water at about 45 degrees centigrade; if not, the animal may die of shock. The injections are repeated at intervals of from five to seven days. The animal should be watched carefully, and if it does not feel well, if it is losing in weight, or if there is any tumor formation, the injections should be discontinued for several days. Three to five injections usually suffice, using the corpuscles from 30 c. c. of blood, from 25 c. c., from 20 c. c., respectively. A week following the last injection a few c. c. of blood are drawn from the rabbit's ear and the titre ascertained; if found unsatisfactory, another injection is given. Sheep's blood will give a higher titre than that of chicken. With three injections, using the quantities mentioned above, I have obtained a titre of 1-3000, using chicken blood. Care must be taken to avoid giving superfluous injections, as the titre would thereby be reduced. One case known to me is where a titre of 1-300 was obtained with seven injections.

Having obtained a satisfactory titre, the rabbit is again tied down on a board and anesthetized. After cleaning the parts thoroughly, the animal is bled either from the ear or from the femoral vessels, the blood being collected in sterile containers, then defibrinated and transferred to sterile centrifugal tubes with sterile caps. After centrifugalization, the serum is carefully pipetted into test tubes, or preferably preserved in hermetically-sealed beads of about 1 c. c. capacity and stored in a refrigerator. A properly-kept amboceptor will last one year or longer, gradually losing its hemolytic power.

It is imperative to standardize the amboceptor previous to each test, in order to determine the smallest amount which will cause hemolysis of a 5 per cent. suspension of erythrocytes. This standardizing is also known as the *titration of the amboceptor.* Into a series of test tubes are placed dilutions varying from 1-500, 1-800, 1-1000, etc., of inactivated amboceptor with equal units of a 5 per cent. suspension of erythrocytes and 1 c. c. fresh complement. Incubate at 37½ degrees centigrade for an hour, shaking tubes at intervals, and note the highest dilution where there is complete hemolysis. Two units of this dilution are used in the test. I may add that all dilutions in

this work are made with .85 per cent. physiological saline solution.

Blood Corpuscles.—The method of obtaining and washing the corpuscles is explained under the head of "Amboceptor." A 5 per cent. suspension in saline solution is used in the test. Another method is to use one drop of the original corpuscle mush for each tube, thus doing away with the suspension. Corpuscles will keep a few days when kept on ice, after which they assume a dark color, being then unfit for the test.

Complement.—This is represented in the serum of the guinea pig; in fact this animal seems to furnish one of the best available complements. The methods commonly employed to obtain the blood are to anesthetize the guinea pig and either cutting the carotid or jugular, allowing the blood to flow directly into a sterile Petri dish, or by carefully drawing a few c. c. from the heart with a syringe. The latter method has the advantage that the guinea pig may live for a varying length of time, thus doing away with the expense of a different guinea pig for every test. The blood is placed in an icebox for several hours, or over night, after which the clear serum is pipetted off. A dilution of 1 in 10 is used in the test. The question may arise, "Why not use the complement normally present in the patient's serum?" The answer is that the patient's blood contains an indefinite amount of complement, and, as it is imperative to deal with known quantities, the complement of the patient's serum is destroyed by heating it at 56 degrees centigrade for a half hour.

Patient's Blood.—The patient may be bled from the basilic vein, or by puncturing either the ear lobule or finger. The blood is collected in suitable glass tubes and set aside in a cool place to clot. The serum which has separated, and which should be absolutely free from corpuscles, is pipetted off and inactivated on a water bath. Care should be taken not to heat the serum above 56 degrees centigrade, nor longer than a half hour, since the syphilitic antibody, which is more or less sensitive to heat, may be partly destroyed. The serum is diluted 1 in 5.

The outfit necessary to carry out the reaction consists of a water bath, thermostat, refrigerator, a suitable cage for the rabbit and guinea pig, glass tumblers, beakers, a quantity of small test tubes, glass tubing, pipetts of 1, 2 and 10 c. c. capacity graduated in 1-100, 1-50 and 1-100, respectively, Petri dishes, centrifuge, Florence flask and a sterilizer.

The test consists of the experimental tube on the one hand and a series of control tubes on the other. (See diagram.)

The reagents having all been satisfactorily standardized and properly diluted, we add to one set of tubes one unit each of patient's serum, complement and antigen; to the other set the same is added, excepting the antigen, which is replaced by saline solution. Allow to incubate at 37.5 degrees centigrade for one hour, after which each tube receives two units of amboceptor and one unit of erythrocytes suspension. Again incubate, shaking tubes gently at intervals of .15 minutes, and remove all the tubes as soon as those not containing antigen show complete hemolysis. This varies from one to two hours.

The tubes are now either centrifugalized or placed in a refrigerator for several hours. The degree of hemolysis may vary, depending upon the amount of syphilitic antibody present in the patient. Thus,

$$-,\ \mp,\ \pm,\ +,\ ++,\ +++,\ ++++,$$

signifying negative, doubtful, suggestive, weakly positive, positive, strongly positive, very strongly positive, respectively.

Owing to its extreme sensitiveness and complicacy, the test should not be entrusted to unskilled hands, since some of the more experienced observers frequently meet with trouble, the causes of which may be manifold and require careful and untiring laboratory scrutiny.

DIAGRAM.

Experimental tube.

(1)  Unknown serum + antigen, complement, amboceptor and corpuscles.

Control tubes.

(2)  Unknown serum + complement, amboceptor and corpuscles. (To prove that the serum itself does not fix complement.)

(3)  Known syphilitic serum + antigen, complement, amboceptor and corpuscles. (To prove that the antigen will fix complement with syphilitic serum.)

(4)  Known syphilitic serum + complement, amboceptor and corpuscles. (To prove that the positive serum will in itself not fix complement.)

(5)  Known healthy serum + antigen, complement, amboceptor and corpuscles. (To prove that antigen will not fix complement in negative serum.)

(6)  Known healthy serum + complement, amboceptor and corpuscles. (To prove that the negative serum will not fix complement.)

(7)  Antigen + complement, amboceptor and corpuscles. (To prove that the antigen will not fix hemolytic system.)

Tube 3 should show absence of hemolysis. Tubes 2, 4, 5, 6 and 7 should show complete hemolysis. Tube 1, of course, depends upon the nature of the serum.

Since Wassermann first reported this reaction, in 1906, numerous modifications have been advanced, a majority depending, however, on the theory of complement fixation. Some of the more common modifications may be mentioned, viz.:

Tschernogubow, *Berlin. Klin. Wochenschr.*, 1908, No. 47, and *Deutsche Med. Wochenschr.*, 1909, No. 15.

Weidanz, *Deutsche Med. Wochenschr.*, 1908, No. 48.

Noguchi, *Journal of Americ. Med. Associat.*, 1908, No. 22, and *Munch. Med. Woch.*, 1909, No. 10.

Hecht, *Wien. Klin. Wochenschr.*, 1908, No. 50, and 1909, No. 10.

Fleming, *Lancet*, 1909, 4474.

Stern, *Zeitschr. f. Immunitatsforschung*, 1909, Vol. I.

Bauer, *Deutsche Med. Wochenschr.*, 1909, No. 10.

Detre and V. Brezovsky, *Wien. Klin. Wochenschr.*, 1908.

The statistics regarding the diagnostic value of the Wassermann reaction are most gratifying. Although this subject may be discussed at length, I will limit myself by briefly saying that in primary lues a positive reaction is present from 60 to 70 per cent.; in secondaries with symptoms, from 98 to 100 per cent.; in secondaries without symptoms the percentage ranges somewhat lower. Late syphilis, including tertiary cases, give about 90 per cent. positive reaction. (Matson, in the *American Journal of Dermatology* of August, 1910, devotes an interesting article on the Wassermann, based on 2667 cases.) A positive reaction may be obtained in lupus erythematoses, framboesia, trypanosomiasis, leprosy, scarletina, tuberculosis, and occasionally in malaria. Also in chronic diseases accompanied by marked emaciation near death, this is especially true with tuberculosis, but under such circumstances there is usually no question of a differential diagnosis of syphilis. A positive case may give negative reaction, because, firstly, the virus has disappeared or is dormant, and there is no specific antibody in the serum; secondly, the patient is taking mercurial treatment, or thirdly, may form that small percentage who, in any case, may give a negative reaction.

In conclusion I may say that in all doubtful cases of syphilis a Wassermann test is by all means indicated. Patients under treatment for a year or more should have their blood tested from time to time. It is surprising to note the change from a stronger to a weaker reaction in some patients who have been under heavy treatment but a few weeks. Practitioners should become more familiar and conversant with its possibilities, and realize that in the Wassermann test they have a valuable diagnostic agent at their command.

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SHOULD ALL MEDICAL STUDENTS SEEK HOSPITAL APPOINTMENTS?

By Charles Bagley, Jr., M.D.

A student matriculating in a medical college is passing another milestone of his career; his ambition is to complete the course creditably and receive a diploma. As he approaches graduation and the anticipation of the diploma is to become a realization, he is astounded with the fact that this is not all he desires and his course in the school has only been a means to an end; namely, the practice of medicine. Men who enter a medical school calmly, almost thoughtlessly, tremble as the time approaches for leaving it; for no one knows better than they how inadequate is the instruction which has been imparted if it be regarded as a final preparation for practice. This instruction is not a completed edifice; it is a mere assemblage of building materials, valuable if ultimately cemented together by clinical experience, but little more than useless rubbish if not supplemented by the binding power of knowledge gained at the bedside.

In considering the question, almost any conscientious student will conclude that hospital experience is advantageous, and often a necessity, in accomplishing his real purpose, so I will not dwell upon the question of the necessity of hospital work, but will ask you to concede me this truth in order that I may utilize the time in attempting to point out to those seeking positions how they may procure and retain them to the good of the patients, the profession and themselves. Again, I do not want to appeal to those who can readily find and acceptably occupy positions, but I wish to speak particularly to those who are not so fortunately situated, and to whom the filling of a hospital position is a great undertaking.

In attempting to bring this class of students and the hospital position into a happy relation we must first lay down what may be considered the ideal course to pursue. This course will at first sight seem impossible, but in the words of Robert Herrick, "We must attempt the end, and never stand to doubt; nothing is so hard but search will find it out."

The ideal course may be briefly outlined as follows:

1. Bedside work during the senior year.
2. Laboratory work during first year after graduation.
3. Two years in the medical service of a good hospital.

He must now look over the work of the years since his graduation with a critical eye, not sparing a strict judgment of himself, and upon the conclusions reached formulate a plan for his life-work.

One of three courses will be open to him:

1. To enter general practice.
2. Seek special medical training.
3. To launch into surgery.

If he decides to enter general practice, he should spend the following year in the surgical service.

If special medical training is desired, he must continue in the medical service three years.

If surgery is decided upon, he should seek an appointment in the general surgical service and learn by close application for four years the general principles.

If he desires to enter a special surgical field, such as eye and ear, nose and throat, or genito-urinary surgery, an appointment in the special service should be sought, after having spent one year in general surgery. Thus, six or seven years must be given to this, the most important period of the physician's career. To many this would seem appalling, and cause great discouragement, but we must remember that this very plan is being followed by many physicians throughout the country at the present time, and it is safe to say that from this class men will be sought to fill the higher positions of the profession. The course we know would not be difficult to the student with unlimited means and exceptional ability, but I wish to show that the student, though lacking these valuable assets, may accomplish the end by realizing that his future is not in anxiety for what lies dimly in the distance, but to do well what lies immediately at hand.

One of the most frequent replies obtained from a medical student is that he would be very glad to accept a hospital appointment, but it is necessary for him to establish himself in practice and pay off the debt which he has incurred by his several years of study, believing that his first duty, after receiving his diploma, is to return the money to those who have so graciously supplied him with

the necessary funds during his course, often forgetting that the greatest debt he owes to those who have sent him to college is to enhance the education which has been given him. An additional debt must be incurred to establish an office, and may mean the placing of another mortgage; whereas, if he accepts the hospital position with all living expenses, but a small amount of money will be required, and the relief to his friends will be much greater. If a student finds himself with absolutely no means, and perhaps a debt upon which he must begin payments, he should seek a lower position on a hospital staff which may carry with it a small salary. He may accept this position with the assurance that success in hospital work depends upon the man rather than upon the position which he may be given. Indeed, I have seen instances where physicians appointed to act as substitutes during the vacation period of the regularly-appointed residents have proven themselves so valuable that extra positions have been created for them, in order that their services might not be lost to the institution. It is astonishing and very gratifying to observe that financial difficulties often become insignificant as the professional ability of the resident is demonstrated and the institution realizes that he is not only the happy possessor of a diploma, but the master of knowledge by which he is soon to become useful to the profession.

Another difficulty frequently encountered is that the student has not made the best use of his opportunities during his course, and is unable to prove to the hospital trustees that he is able to fill their good positions. To these men I would advise intense earnestness and a determination to enter the field, to await an opportunity for a few months, as positions are unfortunately vacated occasionally, either by sickness or otherwise, and a very attractive opening may be found.

A careful examination of the hospitals of this city at the present time would reveal the fact that many have been forced to fill vacancies with men not worthy of good positions, the desirable candidates having become impatient and established themselves perhaps in a rather half-hearted manner in general practice. Do not remain idle during the summer months. Seek a position in a dispensary, a summer camp, in a physician's office or as substitute in some hospital, always looking with a determination to the much-coveted goal.

Having claimed your first hospital position, begin at once to qualify for a higher position by work, study, conscientiousness, sobriety and patience. Newly-appointed residents too often view themselves with satisfaction, forgetting that these positions have existed for years, and have often been filled more acceptably than they are going to be able to fill them. It is the duty of a resident to exact much of himself. He should be unsatisfied, to be able to fill them. He should be unsatisfied, as this is but the portal, the initial step, of the large temple which he is to explore. He must not be dissatisfied, however, as the difficulties he will encounter, while new to him, have been encountered and overcome by those who have traveled before him.

I have mentioned work as a qualification, but will only attempt to touch upon the importance of this work in this connection, as the student may find an entire lecture given to its consideration in the "Master Word in Medicine," by Dr. Osler. By work the stupid man among you is made bright, the bright man brilliant and the brilliant student steady. Let us consider for a minute what would be the proper amount of work for the physician holding a position of this character. To begin with, I think the standard should be placed at the point of physical tolerance, daring to go to this point only, for with the proper amount of work success is assured, unless energy fails. By carefully arranging your mode of living you will be capable of a greater amount of work with less risk of becoming a physical wreck. We know that many are dead ere their prime, sacrificed to carelessness of habits in living and neglect of ordinary sanitary laws. During the early part of your struggle you will be able to spare but a very small portion of your time, energy and money for social pleasures.

Rest and diversion are necessary, but the student too frequently arranges these at the expense of his training. Do not forget the words of Cowper, who said "that absence of occupation is not rest; a mind quite vacant is a mind distressed." A yearly appointment soon passes, and you must endeavor to grasp every opportunity afforded by the position. When you are discouraged and unable to see the results of your labor, do not sit idly down and bemoan your fate, but remember the master word and continue to work, never forgetting that a young man in years may be old in hours if he hath lost no time. In idleness alone there is perpetual despair.

Your work should begin between 7 and 8 A. M. and continue without interruption, except for lunch, until 6 P. M. The evening should be spent in study, not only of textbooks, but of current medical literature and recourse to the Index Medicus.

Lay hold upon the valued function of attending carefully to the details of your work. Let this become a second nature, an attention compelling characteristic. Avoid the danger of ward rounds becoming a mere passing through the hospital twice daily, as required by the hospital rules. Acquire the habit of having all details arranged for the rounds of the visiting physicians. Make a careful study of methods of physical examination, the action of drugs, the effects of food, the draining and dressing of wounds, noting carefully the progress of the disease upon the chart, never forgetting the comfort of the mind and body of the patient. Make an exhaustive study of diseases as they occur in the wards; that is, the study of typhoid fever during the summer months rather than wait until winter, when this disease will be replaced by pneumonia. The best method of studying a disease is to collect all cases occurring in the service and report them to the clinical society. In the operating-room you must first learn to be prompt and quiet, and spare no efforts in learning well the fundamental principles of operating. A good operator must first be a good assistant, and an assistant of high rank must learn well the lesson of forethought, concentration and anticipation, and closely apply the same during each operation. When you have demonstrated your ability to assist the operator, you will find opportunities to operate; perhaps not frequently at first, but the frequency of these opportunities will depend upon the use you make of the first few. In working remember that the man who is making satisfactory progress is going to be called upon to perform duties in themselves very unattractive, but if you are too big for the small duties you will continually find that the large ones are too great for you.

Enter upon your duties with a determination to be patient, remembering that you are fighting for a high position in the profession—for a position to which there is no royal road. Do not expect recognition of each individual noble act you perform, or praise for your personal qualifications. Able residents have been known to believe that they are more capable of conducting the treatment of patients than their visiting physicians, and I can recall a few sad instances where these able men have rendered themselves almost useless in the ward by attempting to discharge the duties of the visiting physician, whereby the details of his own work have been neglected, that of the visiting physician interferred with, a complete failure resulting, the patient often paying the price. The coveted prize is worth a high price, and you must repeatedly render valuable aid with apparently no recognition before realizing a profitable return. The seeds of genius must be scattered to the winds, and though some may perish among the stony places of the world, and some may be choked by the thorns and brambles of early adversity, yet others will now and then strike root even in the clefts of the rock, struggle bravely up into sunshine and spread over their sterile birthplace all the beauties of vegetation.

Study carefully an address, and be able to approach the patient and his family in a manner that will gain their confidence for the institution and yourself.

Conscientiousness is an absolutely necessary requirement, for by this means only can a physician be honest to his patients, his companions and himself. You will have responsibilities ranging from the care of hospital property to that of a human life; your opportunities to deceive your superiors will be many, and you must continually guard against this evil. Hospital internes have but a slight idea of their real importance in the work of a hospital which aims to attain or maintain high standing. If their superiors find their orders are carried out in a perfunctory, half-hearted or careless manner, after a few attempts to correct these faults in the internes, and finding their efforts vain, they give up in disgust their attempts to better their service, the patients' suffering, and the standing of the hospital falls.

A few years devoted to a proper preparation for a high future may seem appalling at first, but when they have been wasted in endeavor to battle with the crowd for a paltry position, they seem little, indeed. Physicians so frequently allow themselves to be decoyed from hospital positions by offers to labor in other fields with attractions apparently greater. This attraction is almost universally money, and one is frequently asked by residents if he would not be standing in his light by not giving up his hospital work to accept a position paying a few dollars more a month. To

the man who is longing for an opportunity of this rank, and who lacks the full appreciation of the principles of a hospital position, it is often impossible to impress upon him that he is making a mistake. I believe that an offer of this kind should simply make him feel that his value has at last increased to the point of this offer, and then see if this salary can be considered the height of his ambition. If not, he should continue in the hospital work until some offer is presented which measures more nearly with his ideal. It is true that the ideas of success are different, but it should be your duty to place your idea as high as possible, remembering that you are far more likely to come below that mark than you are to go above it. Do not give up your hospital positions in order to better yourself during the first few months of service, but remember that it is not only your duty to serve the institution during the time for which you have been appointed, but it is also your duty to yourself to enhance your education by this means as far as possible. You are to embark upon your lifework, and this must be with a definite purpose, and with the proper knowledge of the work you are to perform. Avoid becoming a member of that class of physicians who ruthlessly trample over the bodies of poor and helpless victims, and thus at last enlightened escape from the mazes of their ignorance and attain real proficiency, or to the class beginning with deeply-rooted misconceptions, doomed to perpetual blunders which will cost the public dear, or to the group affrighted at the dangers that beset them, quickly abandon medicine for some less difficult field.

In conclusion I wish to anwser the question by which this paper is titled by reading an extract of a letter I received from a former student who resigned his hospital position after serving but a few months to enter general practice. He writes as follows:

"One has to do a little of everything when he is off in a town like this. I am called upon to pull teeth, do a little surgery, and last month I was ordered to make a post-mortem examination. It is a good experience to round a fellow out and let him put by a little money. Later he can go to a large city and specialize. This is my intention."

Is it not evident that this man, desirous of reaching a special field, has allowed the golden opportunity to pass? In order for him to satisfy his ambition, it will cost his patients dear, and much time must be contributed by him. There can be no doubt that hospital work and hard work offer the quickest and best means of raising the ambitious physician to the loftier levels of superiority, which I earnestly hope it will be the good fortune of all of you to reach.

SYMELUS.

By L. E. Neale, M.D.,
Professor of Obstetrics, University of Maryland,
and
J. M. Elderdice, M.D.

Dr. John M. Elderdice (Class 1905) of Mardella Springs, Md., recently sent to Professor Neale the accompanying photographs of a human

monster that apparently belongs to the variety known as Symelus.

In the magnificently illustrated work of Hirst

and Piersol on Human Monstrosities (Ed. 1891), in Professor Neale's library, it is found that this product of conception belongs to the order of "autositic single monsters, capable of an independent existence." (Part I, page 83.)

"The characteristics of this order are mainly arrest of development, fusion and displacement of important parts of the body."

In the Symelus variety of this order "there is more or less fusion of the lower limbs, but two feet are to be distinguished," and such seems to be

indicated in one of the photographs of Dr. Elderdice's specimen.

The doctor states that the child was born alive of a colored woman 19 years old, in her first pregnancy. It presented by the breech and lived 30 minutes after birth. There was no evidence of sexual organs in the specimen. We hope that Dr. Elderdice will present this specimen to the college museum.

Mr. William Byerly and Mr. Lee of the senior class are acting as assistant obstetricians in the maternity department of the University Hospital.

MEDICINE AND SURGERY IN SAN DOMINGO.

By Manuel E. Mallen of San Domingo, W. I.
Senior Medical Student.

Thousands of people in the United States are so busy every day unraveling the many perplexing problems of medicine and surgery that they probably give but little thought to what is being done by some of their close neighbors. San Domingo, the oldest of civilized places in the West Indies, has almost a million inhabitants, covering a large area. There are seven well developed and modern cities, which have from 15,000 to 35,000 inhabitants; of these Santo Domingo City is the capital, with a population of 20,000 people. The country abounds in plantations of variable proportions in which is grown coffee, tobacco and cane, which comprise the principle exports of the island, and which offer a means of livelihood for many thousands of people. There is much American money invested in sugar refinery plants. With this very brief introduction to the island, I will discuss what the profession of medicine is, and what it is doing. There are about 500 graduates of medicine practicing on the island, allowing one doctor to every 2000 persons. Most of these men are graduates of medical schools in France and some from the Department of Medicine of the "Instituto Profesional de Santo Domingo," an institution embracing three departments—law, pharmacy and medicine. Alopathic medicine is exclusively practiced, the fanaticism of Christian Science and other allied new doctrines which hold the *"secrets"* of cure for so many American people have not even gained an entry among the people. The laws concerning the practitioners of medicine are not as well developed probably as here; we have no examining State board, merely a registration board, which is composed of practicing physicians appointed by the Government, and the candidate for practice presents his diploma with a certain sum of money, and if he has graduated from a recognized medical school he is given permission to practice in the provinces. Our country is one in which the specialist is unknown; everybody is a general practitioner and has to take care of everything that falls into his

hands. There are many hospitals throughout the island. Some are owned by the Government, some by Catholic churches and some are private institutions. Most of these hospitals are well equipped with modern facilities for operating on and caring for the sick. Most large plantations make contracts with physicians to attend to their sick laborers. There are no medical societies, and naturally not a great deal of misunderstanding exists among the profession.

As far as a financial success goes, medicine offers about as lucrative a means of livelihood as any of the learned professions; the charges for services have about the same range as in this country. All physicians advertise in the newspapers, but have no signs on their doors. Obstetrics is the one branch of medicine practiced in a very crude way, midwives being almost exclusively employed. Of course, medicine is crude as compared with its development in the United States, but in the past few years there have been great strides made towards perfection, and probably in a few years to come the situation will present a more favorable picture. There is a school for teaching medicine, supported by the Government, and open to all natives who have sufficient preliminary education. There is no charge for tuition and the faculty is not paid, and there are generally about 40 students enrolled. The course covers a period of three years. After graduating most men go to France to take a post-graduate course. The lectures are delivered in Spanish, but text-books of French authors are chiefly used. Most diseases of the tropics are seen here, although some with great rarity. Hookworm disease is very prevalent and many forms of intestinal parasitic diseases. Malaria is exceedingly common, but is gradually decreasing in frequency, as the people are appreciating the mosquito as the principal causative factor, and crusades for its extermination have been started, marshes being sprayed daily with crude oil.

Malaria tends to occur in Santo Domingo in the most pernicious forms and has caused many deaths, so the fact that our people are awakening to preventive medicine to this extent may mean that further strides will be made in the near future. No steps have been made yet towards combating the hookworm. Among tropical diseases which are seldom seen in this country we may mention ecchinococcus cyst and amebic abscess of the liver. There seems to be a general predisposition towards simple ulcers of the skin, so much so as to be called "endemic ulcers of the skin in the tropics" in text-books. Sugar manufacturing plants supply the hospitals with accident cases. Cholera, bubonic plague, yellow fever and leprosy are still to be seen. Opium and cocaine habitués are very rarely to be seen down there, although alcoholics are as prevalent there as in any other part of the world. Beri-beri, tuberculosis, diabetes, elephantiasis and erisipelas occur with a marked degree of frequency. As far as venereal diseases are concerned, syphilis and gonorrhea occur with disgusting frequency. Chancroids are rare. Abdominal surgery in Santo Domingo is not much practiced, due to lack of material, though appendicitis, gastric carcinoma, hepatic affections and renal calculi are to be found.

COMPLICATIONS OF GASTRO-ENTEROSTOMY.

By Charles L. Schmidt,
Senior Medical Student.

The complications following this operation are numerous, and I therefore deem it advisable to mention them in the order of their gravity from a clinical standpoint. They are as follows:

1. Regurgitant vomiting.
2. Subsequent contraction of the anastomotic opening.
3. Peptic ulcer of the jejunum.
4. Chest complications.
5. Perforation, owing to want of union at point of anastomosis.
6. Adhesions subsequent to this operation.
7. Internal hernia.
8. Death from asthenia.
9. Hemorrhage.

1. REGURGITANT VOMITING.

Formerly this complication was very common, and when severe was often fatal. Today it is

rarely seen unless the technique is faulty. It is due to obstruction to the onward passage of the duodenal contents either from paresis of the intestine, by adhesions, by pressure beyond the jejunal opening, by formation of a spur at the opening point of anastomosis, by acute angulation or kinking of the jejunum beyond the anastomotic opening, or by compression of the colon by the jujunal loop. This complication, which is a serious one, has been proven clinically to be traceable to faulty technique.

II. CONTRACTION OF THE NEW ORIFICE.

There is always a certain degree of narrowing of the new orifice, but this can be avoided by making the opening not less than two inches and approximating the mucous membrane properly.

III. PEPTIC ULCER OF THE JEJUNUM.

Peptic ulcers are very common in the stomach and very likely more common in the duodenum than is supposed, but are rare in the jejunum. The cause of jejunal peptic ulcer is the same as the gastric or duodenal variety. The peptic ulcer of jejunum complicating gastro-enterostomy is seen to follow the anterior more frequently than the posterior variety. This complication may occur from seven days to six or seven years after the operation, and may or may not perforate the intestine.

IV. CHEST COMPLICATIONS.

Pneumonia and pleurisy following this operation are not more frequent than following other abdominal operations. Some claim general anesthesia as a potent factor in its causation. This, however, is an erroneous idea, for they (chest complications) tend to occur even under local anesthesia. Mayo states that the latest theory is that some of the blood returning from the stomach does not go to the liver, and that infected emboli are deposited in the lungs.

V. PERFORATION.

This is a serious complication and very often fatal. It rarely happens when union is procured by sutures. The use of the Murphy button seems to be an important etiological factor in its occurrence.

VI. ADHESIONS.

If the operation be a thoroughly aseptic one, and hemostasis perfect, this complication would indeed be uncommon.

VII. INTERNAL HERNIA.

This may occur by the passage of the small intestine through the loop formed above the juncture of the jejunum and stomach by a small piece of intestine passing through the slit in the mesocolon, and lastly, in the posterior operation, the whole small intestine passing over the efferent loop and becoming strangulated.

VIII. DEATH FROM ASTHENIA.

This complication formerly was rather common, but is very rare today. Ten to twenty years ago, after the operation, the patients were not fed until they were well on to the road of recovery; and, again, they were not operated on until they were extremely weak. These two factors were the chief drawbacks to a successful issue. Today patients are given one ounce of hot water in 16 to 20 hours following operation, which is increased as tolerated, and in 36 hours liquid food is permitted.

IX. HEMORRHAGE.

Hemorrhage is not likely to cause death, because of the fact that the sutures used go through the whole thickness of the anastomotic opening, and therefore act as a compress to the vessels. However, it may occur by erosion of a vessel wall by an ulcer or a cancer, as it may have done though gastro-enterostomy had not been performed.

CONCLUSIONS.

The Murphy button is always connected with uncertain results. If the new orifice is made too small, a relapse may follow. Any method which does not aim at the proper continuity of mucous membrane is apt to be followed by too complete closure of the opening. The risk of peptic ulcer in the jejunum is under 2 per cent., and if the opening is made large enough, and the posterior operation performed, the percentage is less than 1 per cent.

The friends of Dr. Norman F. Hill, class of 1882, will regret to learn that he is seriously ill at the Mercy Hospital.

Dr. Robert Lewis Mitchell, class of 1905, is ill at the Sydenham Hospital with scarlet fever.

THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MAY 15, 1911.

THE ENDOWMENT FUND OF THE DEPARTMENT OF PATHOLOGY.

We are actively at work trying to raise this fund of $100,000. The fruition of our hopes is not yet in sight, but we are making progress. We wish to put an appeal in the hands of every living alumnus, and shall come very near doing so. We hope those who have benefited by the opportunities afforded them at the University of Maryland, and who have prospered in their work, may in their turn aid their Alma Mater in accomplishing this task. Our need is a very urgent one, and we are taking the only means available to us to meet the issue. Of course, we shall appeal also to the citizens of Baltimore, but we ought to be able to show these citizens that our own alumni are doing all they can to aid us in our effort.

The handwriting is on the wall; the unendowed medical school cannot much longer exist.

Brothers, help us to put our Alma Mater on such a sure foundation that when the rain descends, and the floods come, and the winds blow and beat upon our house, it may not fall.

THE APPEAL FOR THE PATHOLOGICAL DEPARTMENT.

The Faculty of Physic, being firmly convinced that the scientific chairs of a medical school should be filled by scientists who give their whole time to the duties of their chairs, and not by practitioners of medicine, have appointed Drs. Randolph Winslow, John C. Hemmeter and Arthur M. Shipley a committee to devise means to bring about this important change in the School of Medicine of the University of Maryland.

The aid of our alumni and friends is therefore asked in raising the sum of $100,000 for the endowment of the Department of Pathology.

Any amount that you may feel able to contribute to this object will be gratefully received, as will also any suggestions or other assistance that may expedite our purpose.

This fund will be administered by "The Trustees of the Endowment Fund of the University of Maryland," an entirely independent corporation, not connected with the teaching faculties of the University.

Subscriptions may be sent to any of the abovementioned, and will be gratefully acknowledged in THE HOSPITAL BULLETIN and in Old Maryland.

THE FUND IS GROWING.

The following contributions have been made to the endowment fund for the department of pathology to May 1:

Robinson bequest, in memory of Dr. Moreau Forrest, class of 1826	$5000 00
Dr. Gideon Timberlake	25 00
Class of 1848, Dr. John J. R. Krozer	50 00
" 1873, Dr. Thomas A. Ashby	100 00
" 1873, Dr. David W. Bulluck	100 00
" 1873, Dr. Robert Gerstell	5 00
" 1873, Dr. Randolph Winslow	100 00
" 1882, Dr. J. Mason Hundley	250 00
" 1885, Dr. B. Merrill Hopkinson	25 00
" 1900, Dr. Salvatore Demarco	50 00
" 1901, Dr. Nathan Winslow	50 00
" 1902, Dr. Arthur M. Shipley	250 00
" 1903, Dr. Hugh W. Brent	25 00
" 1905, Dr. Robert P. Bay	100 00
	$6130 00

LIVING ALUMNI OF THE OLDER CLASSES.

We would be pleased to learn the names and addresses of any other alumni belonging to the following classes:

John W. C. O'Neill, Gettysburg, Pa., 1844.

John J. R. Krozer, Baltimore, Md., 1848.

R. Pinkney Blackistone, River Springs, Md., 1849.

H. R. Roland, Annapolis, Md., 1850.
Henry M. Wilson, Baltimore, Md., 1850.
Philip S. Field, Baltimore, Md., 1852.
Jas. H. Jarrett, Towson, Md., 1852.
Thos. B. Owings, Ellicott City, 1852.
Wm. G. Wilson, Shelbyville, Ill., 1852.
Wm. E. Magruder, Sandy Spring, Md., 1854.
E. Tracy Bishop, Smithsburg, Md., 1855.
Joshua W. Hering, Westminster, Md., 1855.
John D. Cronmiller, Laurel, Md., 1856.
James H. Butler, Baltimore, Md., 1857.
Benj. F. Price, Mt. Carmel, Md., 1857.
J. Ford Thompson, Washington, D. C., 1857.
Samuel C. Chew, Roland Park, Md., 1858.
Nathaniel G. Keirle, Baltimore, Md., 1858.
Edward F. Milholland, Baltimore, Md., 1858.
Somerset R. Waters, Watersville, Md., 1858.
Theodore Cooke, Sr., Baltimore, Md., 1859.
Robert A. Dodson, St. Michaels, Md., 1859.
Ephraim Hopkins, Darlington, Md., 1859.
Jas. G. Linthicum, Baltimore, Md., 1859.
Samuel Quinn, Pocomoke, Md., 1859.
Benj. L. Smith, Madison, Md., 1859.
Thomas P. Robinson, Flintstone, Md., 1859.
James K. Waters, Thurmont, Md., 1859.
Henry L. Naylor, Pikesville, Md., 1860.

ABSTRACTS

REMARKS ON MEDICAL ETHICS.

Dr. Samuel T. Earle, class of 1870, has the following remarks in the *Bulletin of the Medical and Chirurgical Faculty of Maryland* on the above-mentioned subject:

"It is with considerable hesitation that I venture to open the discussion tonight on the subject of 'The Ethical Relations Which Should Exist Between the General Practitioner, the Surgeon and the Specialist' on account of the delicate nature of the subject and the difficulties attending their solution, yet the frequent murmurings and general discontent that we hear whispered from so many sources compel us to open the subject for general discussion among the members of the profession lest a disregard of such warnings should lead us to such an unhealthy condition of affairs in our profession as might bring to us the blush of shame.

"Among such unwelcome conditions may be mentioned a division of fees and the attempt on the part of the general practitioner to do work for which he is unqualified and unequipped. Self-preservation is but a part of our nature, and it is only reasonable to suppose that a man who has honestly given the required time and application to acquire his license to practice medicine should expect to obtain a competent livelihood by this means, provided his efforts are energetic and honest.

"On the other hand, it is perfectly proper that the large field of medicine should be subdivided among general and special workers, because it is generally recognized that certain classes of this work can be better done by delegating it to special workers. These two propositions are readily conceded by all.

"The problem which now demands a solution from us is the proper recognition and remuneration that each should receive for his portion of the work. With the rapid strides made by general surgery and its special branches, together with the readiness with which its brilliant results can be recognized by the laity, this branch of our profession has received much more recognition from the public and a willingness on their part to render much larger remuneration for such services than that of other departments which may have required more thought and study, but which have not been so readily appreciated by the public.

"It is for the members of the profession who can appreciate the character and quality of the work of each one to determine what recognition and remuneration is due each. The man who does the preliminary work, and in many cases makes the diagnosis, but recognizes that a general surgeon or a specialist can accomplish the cure far better than himself, is certainly entitled to more consideration in many cases than he has thus far received. When he is honest enough to make such a statement to his patient, and sends him to the surgeon or specialist for the relief of this special complaint, the surgeon or specialist should be equally honest and liberal in returning this patient to his regular physician as soon as these special results are accomplished, with instructions to report any further trouble of whatever nature to his regular physician, who is to determine whether or not he shall again be sent to the specialist. Should the case be one that does not come within the jurisdiction of the specialist to whom he was first referred, the latter should either refer him back to his regular physician or confer with his regular physician as to whom else

he shall be referred whenever this is practicable. The surgeon or specialist should also see that his brother receives proper compensation for the work he has done, even at the risk of his not getting his regular fee for such special work, but his should all be done openly, with a statement to the patient of his regular charges for such special work, and that they shall only be exacted in full in case the patient is able to pay both the general and special charges.

"It is best that we should discuss this subject freely among ourselves, but it can be settled satisfactorily only by complying strictly with gentlemanly conduct and honesty.

"I can probably make my position in this matter more clearly understood by quoting from Dr. H. C. Würdemann, Seattle, Wash., *Northwest Medicine*, September, 1910. I fully agree with his views:

"'Professional fees are regulated by several factors, kind of services rendered, amount of time consumed, financial standing of the patient and the responsibility. There are no fixed fees for service, the only professional and legal requirements being that they be reasonable and in accord with the class of society to which the patient belongs.

"'The giving or acceptance of commissions to physicians (or other people) for sending patients is an unethical and dishonest act, which has not been tolerated by true physicians from the days of antiquity. It is dishonest because the patient is deceived, and the collusion is more dishonorable than that of the condemned commission business between the doctor and the druggist, long frowned upon by both the profession and laity. It is a cowardly proceeding if either of the doctors is afraid to let the patient know for what he is paying that which he has an ethical and legal right to know. The medical profession is not a trade, and division of fees without knowledge of the patient would be degrading the whole profession to the trade level.

"'You may have spent time in caring for or in accompanying a patient to the consultant's office and feel delicate about submitting a bill for it. Why? That is pure cowardice; the laborer is worthy of his hire.

"'On account of his financial condition the patient may not be able to pay the usual fee of the consultant or surgeon, yet you feel that you are entitled to some payment for your services. The matter is easily arranged; the patient has but to explain his circumstances, and the consultant should be willing to reduce his fees so that the family physician may get some payment; but this all must be done with the full knowledge and consent of the patient. The consultant should be willing, when necessary, on account of the financial condition of the patient, to reduce the bill enough, even to giving his services gratuitously, to allow him to pay the family doctor, but the specialist should not pay over part of his fee because the other is afraid to demand it of the patient.

"'The consultant should be willing to do any special work for what is a customary fee among specialists of proper standings for patients able to pay the same; for others who can pay but little, for the proportion of the usual fee they may be able to give after paying for the general practitioner's services, and in cases unable to pay anything to cheerfully do the work without monetary recompense upon the physician's recommendation; but he should not hire any medical 'barkers' to drum up trade. The strongest reason, aside from the ethics of the case, is that the specialist should value the esteem of the general profession more than business, which he could not retain if he abandoned ethics and customs followed since the days of Galen—yea, even from those of Esculapius.'"

ITEMS

Amongst our alumni located in North Carolina are the following:

CROFT.

Simril N. Henderson, class of 1894.

DABNEY.

Charles D. Wyche, class of 1888.

DAVIDSON.

John Wilson MacConnell, class of 1907.

DEEP CREEK.

John E. Hart, class of 1897.

DUKE.

Augustus C. Boyles, class of 1897.

DUNN.

C. Hector Sexton, class of 1890.

DURHAM.

Archibald Cheatham, class of 1888.
Robert T. Phelps, class of 1898.
Calvin S. Hickes, class of 1904.

Thomas A. Mann, class of 1903.
Robert Alfred Moore, class of 1891.
William Wade Olive, class of 1906.
Rufus J. Teague, class of 1890.

EDENTON.

Harry M. S. Cason, class of 1899.

ELIZABETH CITY.

J. B. Griggs, class of 1892.
William James Lumsden, class of 1869.
Charles W. Sawyer, class of 1885.
Herbert T. Walker, class of 1902.

ELM CITY.

Benjamin Franklin Barnes, class of 1902.
Edwin G. Moore, class of 1883.

ELPASO.

Erastus G. Goodman, class of 1891.

EVALIN.

J. V. Williams, class of 1889.

EVERETTS.

John Watkins Williams, class of 1906.

FAIR BLUFF.

Alva G. Floyd, class of 1885.

FAIRMONT.

J. P. Brown, class of 1883.

FALKLAND.

Jenness Morrill, class of 1888.

FAYETTEVILLE.

Robinette B. Hayes, class of 1906.
James Vance McGougan, class of 1893.
T. Marshall West, class of 1908.

FRANKLINTON.

Richard B. Henderson, class of 1884.

FUQUAY SPRINGS.

James A. Sexton, class of 1873.

GASTONIA.

Charles Edward Adams, class of 1878.
Lucius Newton Glenn, class of 1897.
Frank G. Wilson, class of 1896.

GIBSON.

John Shaw Gibson, class of 1905.

GOLDSBOROUGH.

Thomas Malcolm Bizzell, class of 1908.
Richard E. Lee, class of 1896.

GREENSBORO.

Charles W. Banner, class of 1899.
Louis N. Burleyson, class of 1891.
R. E. Dees, class of 1906.
R. O. Dees, class of 1906.
Julius J. Hilton, class of 1886
Arthur E. Ledbetter, class of 1888.
Arthur Ogburn Spoon, class of 1908.
J. Pinkney Turner, class of 1896.
Buxton B. Williams, class of 1883.

GREENVILLE.

Louis C. Skinner, class of 1901.

GRIFTON.

Walter W. Dawson, class of 1897.
William Cobb Whitfield, class of 1884.

GRIMESLAND.

Claude M. Jones, class of 1892.

GRISSOM.

Ginnada T. Sikes, class of 1883.

HAMILTON.

Benjamin L. Long, class of 1881.

HARRISBURG.

James C. Black, class of 1886.

HAW RIVER.

L. W. McPherson, class of 1903.

HENDERSON.

Edwin F. Fenner, class of 1905.

HENDERSONVILLE.

James L. Egerton, class of 1877.
Columbus Few, class of 1875.

HERTFORD.

Robert Walker Smith, class of 1892.

HICKORY.

William H. Nicholson, class of 1889.
Benjamin Franklin Whitside, class of 1877.

HIGHPOINT.

William M. Jones, Jr., class of 1903.

HUNTERSVILLE.

William W. Craven, class of 1903.
William St. Clair Davidson, class of 1887.

JACKSONVILLE.

E. L. Cox, class of 1889.

JAMESTOWN.

John Edward Foscue, class of 1901.

KEENANSVILLE.

Albert Franklin Williams, class of 1901.

KERNERSVILLE.

Romulus L. Carlton, class of 1906.

KERR.

Charles S. Kerr, class of 1868.

KINSTON.

William F. Hargrove, class of 1901.
Richard H. Temple, class of 1884.

LADONIA.

K. Thompson, class of 1868.
John W. B. Smithwich, class of 1895.

LAKE LANDING.

James Emory Mann, class of 1907.

LAURINBURG.

Peter John, class of 1897.
W. D. Jones, class of 1908.

LENOIR.

Wm. P. Ivey, class of 1883.

LEWISTON.

Wayland L. Mitchell, class of 1895.

LEXINGTON.

E. J. Buchanan, class of 1892.

LILESVILLE.

J. Edwin Kerr, class of 1897.

LINCOLNTON.

Robert William Petrie, class of 1903.

LINWOOD.

James Edwin Cathell, class of 1899.

LITTLETON.

Willis Allston, Jr., class of 1903.
B. Ray Browning, class of 1891.

LOUISBURG.

Emmitt H. Bobbitts, class of 1877.

LOWELL.

George R. Patrick, class of 1879.

LUMBERTON.

John Knox, Jr., class of 1907.
Allen McLean, class of 1908.
Richard Gregory Rozier, class of 1899.

MAIDEN.

Jerry C. Whitside, class of 1877.

MANTEO.

Woodson B. Fearing, class of 1881.

The recent newspapers have published the portrait of Dr. John J. R. Krozer, class of 1848, who is said to be the oldest living graduate in Baltimore of the University of Maryland Medical Department. Dr. Krozer has been practicing for 63 years, and is 84 years of age. Of himself he has the following to say:

"I was born in Elizabeth City, N. C., and raised everywhere. When I was five years old my father died of the Asiatic cholera in its first invasion of this country, and my mother moved with me to Virginia. When 15 years old I entered the United States Marine Hospital, and was there for four years before I entered the University. In those days we doctors started early and worked hard to get our degrees. Two years' study under a physician was then required of a student before he was allowed to enter the University, but its diploma, together with that of the University of Pennsylvania, was even then recognized in France, where medicine was at its highest. Those two universities were the only chartered schools in the United States the degrees of which were recognized abroad."

Dr. Krozer was born August 30, 1827, and was the son of Dr. John Krozer. He was educated at the Military Academy of Portsmouth, Va., entering at the age of 15 the United States Marine Hospital, above mentioned, and later the University of Maryland, from which he graduated in 1848. He resides at 662 West Lexington street, Baltimore.

Dr. Krozer has in his office an excellent engraving of the United States Marine Hospital at Portsmouth, in which he began the study of medicine 69 years ago. He has owned it since 1855, when it was engraved by Caspar Bohn of Washington. On it is depicted the old sidewheeler Herald of the Bay Line, which was the twin ship of the Georgia, both of which have long since gone to the junk pile. He was also on board the United States frigate St. Lawrence when she was launched in 1845 from the navy-yard at Portsmouth. She was built of wood, and was a three-masted sailing vessel.

The next commencement of the university, which he will attend, is the sixty-fourth which he has seen since he entered on October 15, 1846.

A portrait of Dr. James H. Jarrett has been placed in the hall of the Medical and Chirurgical Faculty of Maryland, 1211 Cathedral street, Baltimore, by the Baltimore County Medical Association. The *Sun* published the portrait of Dr. Jarrett, and gave the following account of his life:

Dr. Jarrett was born February 24, 1832, in Harford county, and is of English descent.

The doctor's grandfather, Jesse Jarrett, was born in Harford county, where he became a leading farmer. He had a son, Asbury, who was a soldier in the War of 1812, and later became a prominent merchant of Baltimore. Another son,

Jesse, was a farmer in Harford county. The only son of Jesse Jarrett by his second marriage was Luther M. Jarrett, who was Dr. Jarrett's father. He was born in Harford county in 1804, and was a successful farmer and merchant. About 1837 he platted the village of Jarrettsville, which was named in his honor. He was one of the leading Democratic politicians in Harford county, and represented his district two terms in the Legislature, and held several positions of trust and honor.

In 1848 Dr. James H. Jarrett entered Dickinson College, where he completed his education, and entered the medical department of the University of Maryland. He graduated in 1852, and practiced for nine years at Jarrettsville. At the breaking out of the Civil War every member of the Jarrett family was an advocate of the Confederacy except the doctor, and when he announced that he was in favor of the Union and intended to enter the Union Army his course was bitterly opposed by his family.

Undaunted by opposition, Dr. Jarrett at once entered the Purnell Legion, organized by Col. William H. Purnell, as an assistant surgeon, and after serving a year was promoted to surgeon of the Seventh Maryland Infantry, organized and commanded by Col. E. H. Webster of Harford county, and attached to the Army of the Potomac. His service was on the Eastern Shore of Virginia, and he was within hearing distance of the guns at the battle between the Monitor and the Merrimac. He was at the headquarters of Captain Duvall, at Cherrystone, when a messenger came up and announced that he wished to send word to Washington of the battle. Captain Duvall furnished an orderly and horse to take the messenger to Eastville to telegraph to Washington.

Finally his ardous duties and overexertion caused his health to break down, and in 1864 he resigned on account of disability. While in the army he became acquainted with many of the leading residents of Towson and vicinity, and so strongly was he attached to them that in 1865 he decided to make his home at Towson, and purchased property there. When he started at Towson the leading physician was the late Dr. Jackson Piper.

In 1855 and 1856, as a Whig, Dr. Jarrett served in the State Legislature from Harford county. He was a member of the State convention which nominated Thomas Holliday Hicks for Governor. There was a three-cornered contest between James B. Recaud, William H. Purnell and Hicks. Dr. Jarrett favored Purnell, but on the last ballot changed to Hicks, and thereby made him Governor.

While his family were well known as Democrats, Dr. Jarrett cast his lot with the Republican party in 1860, and has voted the ticket ever since. At the close of the Civil War he became the public storekeeper at the custom-house, and held the position for four years. Under President Arthur he was made a member of the United States Pension Examining Board, a position held at present by his son, Dr. Harry S. Jarrett.

Governor Lowndes made Dr. Jarrett one of a commission of three to compile and publish a record of the Union soldiers of Maryland during the Civil War. Dr. Jarrett was in Baltimore April 19, 1861, during the riot.

In 1852 Dr. Jarrett married Miss Julia A. Spottswood, daughter of William Spottswood of Carlisle, Pa., who died some years ago. He has a son, Dr. Harry S. Jarrett, who is a graduate of the College of Physicians and Surgeons, Baltimore, and two daughters, Mrs. William A. Lee and Miss Julia Jarrett of Towson. Mr. William B. Jarrett of the Internal Revenue Service is a brother.

Dr. Randolph Winslow, class of 1873, has received the following letter from Dr. Charles Edward Scholl of Camden, Ind., a classmate. The Michael referred to is Dr. J. Edwin Michael of the same class, now deceased. The other members of this class referred to are Drs. Thomas A. Ashby of Baltimore; John H. Rehberger, also of Baltimore; Truman E. Fairall of Tecumseh, Neb.; James A. Sexton of Fuquay Springs, N. C., and David William Bullock of Wilmington, N. C.

The letter reads:

Camden, Ind., April 15, 1911.

Randolph Winslow, M.D.,
Baltimore, Md.:

Dear Doctor—I received your letter of the 13th inst. yesterday, and to say that I was surprised and delighted but half expresses my true feeling. My wife and I early last fall planned to spend the winter in Baltimore, and had even gone so far in carrying out our plans as to engage rooms on West Fayette street, but, unfortunately for us, my presence here was required, and we were compelled

to give up the visit altogether. I wanted to look up old friends in your city, and to renew old acquaintances. I had often wondered what had become of the old boys of the class of '73. You were the only member of our class that I could locate, as you were the last one—you and Michael —that I had met, and one of the professors of the School of Medicine of the University of Indiana told me that he had met you at Chicago or Washington, I have forgotten which. Your kind letter gave me just the information I wanted. Some of them very familiar; some I recalled with an effort, as I have been so long out of touch with everyone and everything connected with the old University. I came here nearly 36 years ago, and have had a very busy life, with all the hardships and pleasures incident to a country practice, and now that I am growing old can say, with all others in this life, my reward has been all that I deserved. One of the greatest pleasures your letter afforded me was to run over the list of survivors of our class, to recall their peculiarities or characteristics as I remember them. Why, Doctor, it was almost like meeting each one again! Ashby, Rehberger, Fairall, Sexton, Bullock, and Michael, cut down in his prime; they were a fine lot of fellows! You ask why I made myself so scarce, and the reply comes naturally enough. New scenes, new associates, new duties mean a new place in life. I have visited Maryland many times, and several times passed through Baltimore, but each time was impressed with the fact that I had lost my old place there by my removal, and my place was here. If I live I am coming back for a good long visit—perhaps next winter—and then I will give myself time enough to hunt up and meet all the old friends. Remember me kindly to all the class in Baltimore, and accept my thanks for your kind letter, and best wishes for you and yours. I am,

Very truly yours,
C. E. Scholl.

The following members of the class of 1911 have secured appointments as follows on the staffs of Baltimore hospitals for the ensuing year: At Bayview—Joseph Enloe Thomas of South Carolina, Paul Pressly McCain of South Carolina, William Clinton Marett of South Carolina, Herbert Augustus Codington of Georgia and Grafton Dent Townshend of Maryland as assistant resident physicians; Raymond Garrison Hussey of North Carolina as chief physician of the tuberculosis department; Burt Jacob Asper of Pennsylvania as chief physician of the department of mental diseases. At the Hebrew Hospital—Charles Lewis Schmidt of Maryland and Isaac M. Macks, also of Maryland, assistant resident physicians, and Isadore Hirschman of Maryland as resident pathologist. At the Church Home and Infirmary —George Y. Massenburg, resident physician.

Miss Mary Constance Wiggin of New York, University Hospital Training School for Nurses, class of 1910, has received an appointment in the United States Naval Nursing Corps.

BIRTHS

Dr. Allen Kerr Bond, class of 1882, and Mrs. Bond are rejoicing over the birth of a daughter, Christiana Birckhead Bond, on March 17, 1911.

DEATHS

Dr. John Richard Thomas Reeves, class of 1858, died at his home in Chaptico, Md., April 14, 1911.

Dr. Reeves was born at Charlotte Hall, St. Mary's county, Maryland, October 8, 1832. He was the son of Thomas Courtney Reeves and Mary Elizabeth Edwards. His early education was received at Charlotte Hall Academy. For some years after graduation he taught in private families, afterwards matriculating at the University of Maryland. Dr. Reeves was at one time tutor in the family of Governor Samuel Sprigg.

Dr. Reeves was devoted to his profession, and though during the last few years of his life he was not engaged in active practice, he never lost interest in the work of his fellow-practitioners.

He married on October 16, 1860, Miss Elizabeth Ellen Hayden, who died in 1899. Dr. Reeves is survived by six sons—Thomas Garner, George Richard, John Courtney, Samuel Sprigg, William Pinkney and John R. T. Reeves—and one daughter, Miss Bessie C. Reeves.

One incident of Dr. Reeves' life which he loved to relate was a trip he made to Gettysburg immediately after the great battle there in order to

render medical aid to a mortally-wounded brother-in-law. After some difficulty in getting through the lines he finally succeeded in reaching the object of his quest. While there a wounded Confederate soldier, who thought he was about to die, handed his sword to Dr. Reeves, as he did not wish it to fall into the hands of the Union soldiers. Dr. Reeves managed to get the sword home without being detected, and a full 20 years after met again by a round-about method the owner of it, who was able to identify the sword by the blood spots on the handle, still perceptible.

Dr. Jacob Dimmitt Norris, class of 1878, died at his home, 1221 West Fayette street, at 12.30 o'clock April 24, 1911, of heart trouble. He had been in poor health for several weeks. Dr. Norris was born in Belair, Md., August 1, 1854. He was the son of Lloyd A. Norris and Mary A. Stansbury Norris, and a descendant of Sir John Norris, an admiral in the British Navy. He received his earlier education at the Springfield Institute, near Fallston. When Dr. Norris was 19 years of age the Civil War broke out. He entered the Confederate Army at Nashville, and fought throughout the Civil War. At the close of the war he went to St. Louis, Mo., and later to Eldorado Bar, N. M., and still later to Helena, Mont., where he engaged in mining. In this, however, he was unsuccessful, and later took a position on a ranch. This, also, was not to his taste. He then went to Walla Walla, Wash., and studied medicine for a year with Dr. J. C. Blacklock. He then started East on horseback, in 1876, coming as far as St. Louis in that manner and by train the rest of the way to Baltimore. A year later he entered the University of Maryland, graduating in two years' time. He received an appointment as vaccine physician by Mayor Latrobe, and was reappointed by Mayor Hodges, who also appointed him commissioner of Franklin Square. President Grover Cleveland, during his second term, appointed Dr. Norris as president of the second Pension Board of Baltimore. He was one of the first men to join the Fourth Regiment of the Maryland National Guard, and at the time of his death was chief surgeon, ranking as major. He accompanied the regiment on several trips, notably the one when they were ordered out to quell the riots in the Frostburg (Md.) mining districts. During the administration of Mayor Thomas Hayes Dr. Norris was elected to the City Council from the Twenty-first Ward.

He married in 1881 Miss Mary Eunice Warfield of Frederick county, who survives him. He also leaves two daughters—Misses Hester and Jessie Norris, and one son, Dr. Lester D. Norris, class of 1908, surgeon for the Baltimore & Ohio Railroad at Wheeling, W. Va. The Masonic order, of which Dr. Norris was a member, had charge of the funeral services. Interment was in Lorraine Cemetery.

LABORATORY REPORT OF THE UNIVERSITY HOSPITAL.

Month of April.

Blood Examinations.

Leucocyte Counts	156	
Erythrocyte Counts	103	
Differential Leucocyte Counts	7	
Hemoglobin Determinations	103	
Smears for Malarial Parasites	8	
Blood Cultures	2	
Wasserman Tests	18	
Widal Tests	5	
		402

Urine Examinations.

Routine Urinalysis (chemical and microscopic)	388	
Total estimation for Urea	2	
Total estimation for Albumen	4	
Total estimation for Sugar	2	
		396

Miscellaneous.

Gastric Contents (chemical and microscopic)	11	
Feces (macroscopical, microscopical and some cases chemical examination)	12	
Sputum Examination	18	
Bacteriological Cultures and Smears (from operative cases)	8	
Examination of Spinal Fluid	2	
Section of Tissue for Microscopical Examination	32	
Autopsies	4	
		87
Total		885

Dr. J. L. Hirsh,
Dr. H. J. Maldeis,
Dr. R. Diller.

THE HOSPITAL BULLETIN

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ADDRESS OF DR. HARVEY W. WILEY, DELIVERED AT THE LYRIC THEATER JUNE 1, 1911, at 4.15 P. M., ON THE OCCASION OF THE GRADUATING EXERCISES OF THE UNIVERSITY OF MARYLAND.

Members of the Faculty of the University of Maryland, Students and Graduates of the University:

As a farmer I am struck with this fact today—that there is one crop in this country that never fails, no matter how dry it may be nor how late the frost may come in the spring, nor how apathetic a husbandman may prove himself to be, the crop of bachelors and the crop of doctors never fails us. But it is, I suppose, a mark of the wonderful prosperity of the country that this crop goes on, ever increasing in volume. As I saw this great concourse of gowned young men and one or two young women—for I see you have a sprinkling of a competition which you have got to look out for in the future—I wondered where you are going to find places; if you are all going to get jobs. And remember, that there are other universities besides that of Maryland in this country. I have been going now for about two weeks almost every day addressing people who are graduating, so to speak, so I have seen a great many of them, and I hope that the pleasure which I get upon looking into the faces of young graduates may never be denied me as long as I live and have a voice. I hope that the institutions of this country will continue to ask me to come to their commencements, because I can assure you that great as your pleasure is in receiving your diploma, it gives me even greater pleasure to look into the faces of these young people who are to be the arbiters of the destinies of this country. So I am glad to see you to-day; I am glad to see such numbers of you, so many who have completed the courses assigned and who are ready, I suppose, to begin the more active duties of life. Some of you are unfitted for that yet, because I see some are only bachelors of arts or bachelors of science. Now, with what profound pity you must look down upon a bachelor of arts, you who bear the dignity of doctor of medicine or of law! The one is only a preparation for the degree which you have already received, but let me tell you bachelors of science and bachelors of arts that there is not so very much difference sometimes, after all, between the amount of learning which a bachelor of science or of arts may have and that which is borne by a doctor of medicine or a bachelor of law. I have been opposed for a great many years—but I do not want you to draw from this any reflection upon you young bachelors or doctors of medicine—but I have long been of the opinion that it is not proper to give the degree of "Doctor of Medicine" to a graduate in medicine, because the word "doctor" does not mean a physician any longer. It never did; although in this country when we speak of a man as a doctor we associate the idea with the practice of medicine in some way in one form or another. The word "doctor" does not have anything to do with medicine necessarily. The term "doctor" means one who is learned, one who has approved himself as a man of learning. I think the English custom is a great deal better. It is a long while after graduation in medicine before the English physician can assume the title of "doctor." But that has nothing to do with the case today. You are doctors, or soon are to be, and I do not suppose you ought to be deprived of that pleasure, but it is a long while before you can get to be doctors of laws, and some of you never will. I was almost

as old as I am now before I got to be a doctor of laws. You do not have to be a lawyer to be a doctor of laws. But the term doctor, I claim, should be reserved to give to a man after he has proved himself in the active field of service. In the old times, and probably yet, there was a fiction which said: "The king can do no wrong." That is to say, that there is a divinity that doth hedge about the king which prevents him from doing a wrong. That naturally goes with the idea of the divine right to rule. And in those olden days, too, in the feudal times, the lord or baron was supposed to be the protector of his people. They had no other protector except their lord. If he did not look after them they had nobody to look after them. And hence there came to be associated with the lord of the realm, the baron of the realm, an idea of justice or protection and of support among his people, and hence when this title was given to the lord of the realm, as it usually was, he became the lord or the aristocrat or noble of the province. If he was the right kind of man—and being a man he generally was the right kind of man, because most men are—he looked out for and protected his people. If you have studied Greek you will know that the term "aristocrat" means the rule of the best, *agathos* being the Greek for "good," and *aristos* being the superlative. I mention this because it is about 40 years since I studied Greek, and I want you to understand that I have not forgotten it. These aristocrats all looked after the people and protected their rights in those early days, and therefore there came into existence this idea which the French have so beautifully expressed by the phrase *noblesse oblige*. The noble, the high position imposes an obligation, in other words, upon the men who have achieved it. So I say to-day that the distinction of receiving a diploma from this ancient and honorable University imposes upon each one of you an obligation, an obligation as the minister has so beautifully said in his prayer, to serve humanity. And let me tell you that the only good you will ever get out of your diploma will be in proportion as you realize the obligation it imposes upon you. To be sure, the old diplomas—and I suppose the new ones also—used to read in very bad Latin that you were admitted to all the rights and privileges of the academy, but in the olden times they added to it *and also all the duties thereunto pertaining*. This is not a mere admission to a privilege, but it is an admission to a privilege on the condition that the duty which is attached to that privilege is performed.

So I am going to speak to you today on that idea of *noblesse oblige*. The obligation which graduation imposes upon each one of you in the particular course of duty which you are to perform is embodied in this idea of *noblesse oblige*. Now, in a graduation of this kind, where all the schools are represented, I can hardly select any particular one to whom to address my remarks, and so I am going to make them as general as possible, so that all may be included.

Now, let us begin with this distinction—that the difference between the man who bears a diploma and the one who does not is one of broadened intellectual conception. The man with a diploma ought to have a broader view of things than the man who has not a diploma. Sometimes that is not the case. Some quite learned men have never been to college, and some who have been through colleges and universities and who have diplomas are pretty narrow, I have found, in their views, and the principle which I enunciate, then, is a general one, and does not always apply. But if you do not have a broader view of things, then your course in this institution has been in vain in so far as you are concerned. If you have not knowledge and a knowledge how to apply knowledge, which the man who does not bear the diploma has not got, then you have not done your duty in this institution or the institution has not done its duty to you—one of the two. Now, having this increased power, having become a nobleman in the true sense of the word, there is imposed upon you that obligation of *noblesse oblige*. What are some of the things that are imposed upon you? In the first place, you should become good citizens of this country. That is the first thing you ought to look out for—to see that you have the right view of public affairs. Now, I am not going to give any tirade on politics, only to say this—that we are too apt in this country, all of us, to go blindly in our political creed. We all have been brought up, perhaps—I know most of us have—to some particular religious creed, and we are very apt, when we grow up, to follow that creed. Sometimes we get away from all creeds, which is an unfortunate thing. It is better to follow the one you were brought up in than to have none at all, even if that be faulty. And the same is true with politics. You ought to have

some politics, and if you haven't time to have some of your own, you ought to take those of your father, if you have faith and confidence enough in your father's politics, and I trust you have. If you haven't time to study them for yourself, then follow along in the line in which you have been brought up. But it is very hard, indeed, to break away from those moorings, and yet the duty of every young man and every young woman is to have some politics. I say "young woman" because you are going to vote very soon. I see you back there in the audience; you are going to have the ballot just as sure as I stand here, and you are going to take part in the civic uplift of this country, and it is the duty of every young man and every young woman to think about political affairs, and not to be blindly led by your leaders, whoever they may be. This is a country of free thought. We have not had any restriction placed upon a man's thoughts and their expressions unless they tend to disrupt society. As long as your thoughts are right, as long as they are for the benefit of mankind, you have your right to your thoughts and your right to your religion and your right to your politics and your right to your philosophy and your right to your medical profession, or whatever you want, and it is your duty to be an independent thinker on matters referring to the welfare of the State, whether it be of the city or State or the nation. So I see a development in this country, and largely among college and university-bred men, toward that spirit of political independence which means so much for the welfare of our country, and so much for the perpetuation of our free institutions. Now, let me tell you young people that we are entering upon an age of ferments; the whole civic body is teeming with those organisms which produce the fermentation of the civic spirit, and we are having developed in this country dangerous tendencies as a result, and as a natural result, of the condition of affairs which exist in this country today. You cannot expect the people of this country to sit quietly by and see all the wealth of this great nation in a few hands. There must be something wrong when conditions of that kind prevail. Now, how are those conditions to be met? I say by philosophical inquiry, by a judicial spirit of inquiry, and not by mob and force and violence, as those conditions have been met in other countries, and will be met in this country if they are not met in some other way. Therefore, I say the solution of these great problems of socialism and anarchy and the rights of the common people and the rights of the workmen and the housing of the workmen and all those things which work for public sanitation and welfare and civic uplift have got to be solved by philosophical inquiry and a judicial disposition of the mind. And it is the educated people of this country who are going to solve those problems; the graduates of our universities and of our colleges are to be the leaders in this, and you as citizens will have to face these problems in the near future. They are upon us now, and you have to act wisely and well in order that their solution may be a proper one. We do not want to see this country precipitated into the throes of a revolution because the proletariat is deprived of its rights. The man who is born in this country has the right to live and the right to earn his living and the right to work, and the right to receive the wages for his work, and every time that a dollar is improperly diverted to a coffer where it does not belong, just that moment one dollar is taken from what the people of this country should have as a common inheritance. You have read Henry George and his theories of the land. Nobody owns land in this country. *We* all say we own land, and think we do, but there is not a man in this house, nor in any part of this country, who owns a foot of land. He holds it by the sufferance of the public, and the State can come in and take every foot of land that he owns to-day if it wants to. Why do you have to pay taxes on things you own? Because you do not own them; if you did, nobody would have any right in them at all. And we recognize the right of taxation and the right of eminent domain and the right which every State had to take not only the property, but the lives of its citizens for the public service. Just think for a moment, then, that you are not independent; you are not standing alone, but you owe your property, your service and your lives to your country, and hence as citizens this sense of obligation, this *noblesse oblige*, rests upon you to become good citizens.

Then you want to make good husbands and fathers. And while I believe in the rights of women, that a woman has every right in the world that a man has, she has the right to vote, she has the right to earn her own living and she has the right to enter any profession she chooses to enter; but the woman's sphere is not alone in professional life; it is as a mother and in the

home, and there is only work enough in this country for half of the grown people to do; even if there were not, I would not want to see the women do the work; I do not want to live in a country where the men sit in idleness and the women do the work, because, while a woman can adorn an idle chair, a man cannot. At the same time I would not deny any woman of this broad land a single right that I possess. She has a right to her own views in politics, she has a right to own property; just as much as anybody can own property; she has a right to rule her husband if she can—and most of them can—and she has a right to vote, and she has a right to be a physician, and also a minister of the gospel and a citizen of this great republic, the highest honor of all. But with those rights—and in this it is the same as with the diploma—go the duties of women, and the duty of the woman is at the home, to be the mother. That is her duty. Every right has a duty imposed with it, every single one. No man ought to claim any protection under the laws of his country who does not give some service to that country. The right of protection under the law rests wholly upon the duty which citizens render to the State. So we cannot claim that protection unless we render that service.

Then again, you young people have a duty which you have already performed to a large extent, and that is in a preparation for this service which you propose to render. You have already, by passing the examinations and receiving the approval of your faculties, shown that you have prepared yourselves for the several duties which you are proposing to undertake. But do not fall into this error of thinking that the period of preparation and study is past. It is only beginning. You have only fabricated the implement up to the present time, the plow which you are to use in the cultivation of the field, and I do not care how skilful you are in theories, it does not necessarily spell success. I could sit down, if I knew how, and teach a man how to make a watch, and tell him how every single part of that watch was to be made, what size it should be and how it should be put together, but I would not like to trust that man to make a chronometer to run the universe by the first time he attempted it. He would make a sorry spectacle of it. Once I heard a story of an eminent specialist, an oculist, who was complimented on his skill in being able to save the sight of the eyes. He saved the sight in cases that were almost hopeless, and when complimented upon his skill he said: "Yes, I am skilful; I can do these things; I can operate upon an eye with the greatest precision and restore apparently a vision that has vanished and prevent the destruction of that which seems to be going," but, he says, "I destroyed a bushel of eyes before I learned how to save one." Now, it is hard on the people who have the bushel of eyes. I expect it is going to be hard on some of the sick people in this country when they first fall into the hands of these young doctors, and hard on some of the clients who go before the courts represented by some of these young lawyers. I fear they will be mulcted more heavily than they should when these young lawyers take hold of them. And I expect that many a tooth will ache that ought to be in placid retirement when these dentists get hold of them, and many a person, I fear, may have qualms in his stomach when the young pharmacist first prescribes for him.

They tell a story of a man who had a lawyer who was very skilful. His client knew he was guilty and that he was going to be convicted. It was a civil case, so he did not have to be in court at the time. So the lawyer presented his case to the jury, and much to the lawyer's surprise the jury brought in a verdict of not guilty. He telegraphed his client, "Justice has been done," and he received immediately a reply by telegram, saying, "Appeal at once."

A mother once called in the old-fashioned "root and yarb" doctor for her boy, who was suffering with chills and fever. Now, I was born and brought up in Indiana, and I know what the "ager" is. A man was not a respectable citizen in that State unless he had an "ager-cake" as big as a bread basket. It was his title to nobility. The mother called in this old doctor, as I said, who prescribed for the boy. He took from his stock of herbs one of the roots, and he scraped it very carefully and put it in a glass and poured hot water on it and set it to one side. Then he scraped another piece from the same root and put it in another glass and poured hot water on it and set it to one side. Then he said to the mother: "When the boy has a chill you give him the first preparation, and when he has fever you give him the second one." "But," she said, "you took those both from the same root, didn't you?" "Ah, yes, I did, but did you notice that I scraped the first one up? That is high-cocka-

lorum. And I scraped the second one one down—this is lo-cockahighrum."

Now, I fear that much of the beginning practice of the young physician will be of the high-cockalorum and the lo-cockahighrum stripe, and I say it is hard on those persons who lost the bushel of eyes in order that you may become skilful, but we have to take these chances in this world, and if we are brave enough to employ the young physician or the young dentist or the young lawyer, we at least confer a service on those who come after us.

Therefore, I say that the preparation or acquiring of the skill which you have largely accomplished must be supplemented by its actual practice, and that is where the judgment, the intelligence and the good sense—what we used to call "horse sense" (I do not know why they called it that, because I have seen some horses that have less sense than any human beings I ever saw), but the good horse sense of the individual, his individuality, his power of discrimination—come into use, and it makes a success of one man, and the lack of it makes a failure of another. Now, you are not all going to succeed. I am not going to specify those of you who are going to fail, so you need not take it personally. But here there are 210 graduates, I may say, and at least 10 of those are going to make failures of life. You can draw lots, all of you, to find out who they are, because I cannot tell you to-day which ones they are, but partly it will be the result of environment in which they are placed, and largely it will be the result of the subject himself. There are some people who would be hungry if you were to turn them loose in a banquet hall filled with all the best things to eat in the world, and if you were to tell them to help themselves they would not know how to eat. There are some people who would fail under the most favorable circumstances for success. There are others who will succeed where the environment seems almost hopeless. And I tell you that one of the principles which is the most important in this respect is wise patience. The man who will calmly wait under difficulties, under stress, under hardships, under privations, feeling that he has the stuff in him to make a success, and that he will succeed if he just keeps on, that man is almost certain to succeed, almost certain, I say. Yet, it is one of the hardest things in the world to teach a person the faculty of waiting. The young man wants to bound at once into success. He has had four or six or eight years' study in preparing for life, and now he expects in one year to make a reputation and a name for himself, and to make an income. Now, that is impossible, except in rare instances, at the present time, so the man who patiently waits, and who works while he waits and never gives up, never gives up his purposes, holds to the one purpose, is bound to succeed. But, young men, you are never going to succeed by trying this thing to-day and that thing tomorrow. You want to try this thing to-day and tomorrow and all the time when you make up your mind to try it. Never give up. I never saw a man yet who got into a habit of going from pillar to post trying this and trying that who ever made anything of himself worth making. You make your way by perseverance and patient waiting. And do not be discouraged because you do not become famous in a day, because you have no clients the first day you put your shingle out, because you have poor success when you do get them. Stand by your guns. Be patient, be hopeful, be reliant.

"Did you tackle the trouble that came your way
With a resolute heart and cheerful?
Or hide your face from the light of day
With a craven soul and fearful?
O, a' trouble's a ton, or a trouble's an ounce,
Or trouble is what you make it,
And it isn't the fact that you're hurt that counts,
But only how did you take it?

"You are beaten to earth? Well, well, what's that?
Come up with a smiling face;
It's nothing against you to fall down flat,
But to lie there—that's disgrace.
The harder you're thrown, why, the higher you bounce;
Be proud of your blackened eye!
It isn't the fact that you're licked that counts;
It's how did you fight—and why?

"And though you be done to the death, what then?
If you battled the best you could,
If you played your part in the world of men,
Why, the Critic will call it good.
Death comes with a crawl, or comes with a pounce,
And whether he's slow or spry,
It isn't the fact that you're dead that counts,
But only how did you die?"

So stick to it; don't give up. And always believe in yourself and in your ability and in your future, and do not get married until you get something for your wife to live on. It is hard enough for one man to starve, but it seems to me to be a great deal worse if there are two to starve. And if you love your wife as well as you ought, you wouldn't eat anything, so that she could have a full meal. So just wait a while. Do not wait too long, however. Do not wait until you get ten thousand dollars a year; when you get a thousand dollars that is enough. Do not wait too long. Let your faith be always in the future.

And then there is a service which you owe to the State. You ought to make a good living, you ought to prepare yourselves to do it, and to work hard to do it, but that is not the object of life; that is not the ambition which is carried in the phrase *noblesse oblige*. True, every man wants to make a living, and he must make a living, and does make a living, except in extraordinary cases, but the acquisition of wealth should never be the sole ambition of any educated man. Let the uneducated people get rich; let the educated people serve the State. In that service you must sacrifice to a large extent your own personal views and preferences. I do not believe there is a man living who ever really has a proper feeling of contentment and self-respect who cannot look back every day on some service he has done humanity. The mere selfish acquisition of wealth, it seems to me, is the most unsatisfying feeling that could come to a human being. But if you feel that you have done your client a service before the bar, if you feel that the sick man's pains have been alleviated and he has been put upon the road to recovery, if you feel that the man who leaves your dental chair has a better set of teeth than he ever had before, and if you feel that the prescription you put up at the corner drug store is of the purest and best drugs, you can feel that you have done a service to humanity in doing that. In other words, a service well done—I do not care how menial it is—is a service to humanity. They say of the Roman Senators that in derision of Cato, and being angry with him, they created the office of Commissioner of Sewers, and to humiliate him they appointed him the commissioner of the great *Cloaca Maxima*, and he so discharged the duties of that despised office, with such benefit to the State, that ever after that to be Commissioner of Sewers was the highest honor to which a Roman Senator could aspire. So never despise a thing because it is menial, but do it well. I read the other day of a man who got a prize of one hundred dollars for ploughing the best furrow in a field out in Illinois. I would have been as proud to get that hundred-dollar prize as if I had won the gold medal at this University. Those of you who are going to get those medals to-day know how proud you are. But I do not care how menial the service is if you do it well, especially a service to humanity, and unless it is done well you are not doing your duty to humanity.

Service should be the cry, the ambition of every educated man. Service, service, service! To do something to help the world along. The world will recognize you not in proportion to your claims upon the world, but in proportion as you serve the world. The world has no sentiment. You are going into the great capacious maw of this great world, and you will be eaten up, swallowed whole, and the world will pay no attention whatever to you until you make yourself felt upon the surface of the earth by your service, and not by your claims, nor by your diplomas nor your science, but by what you do. That is the measure by which the world will gauge you and judge you in the future. Service! Do something to help the world along.

"There are hermit souls that live withdrawn
In the place of their self-content;
There are souls like stars, that shine apart
In a fellowless firmament.
There are pioneer souls that blaze their paths
Where the highways never ran,
But let me live by the side of the road,
And be a friend to man!

"Let me live in a house by the side of the road,
Where the race of men go by—
The men that are good, and the men that are bad—
As good and as bad as I.
Why should I sit in a scorner's seat,
Or hurl a cynic's ban?
Let me live in a house by the side of the road,
And be a friend to man!

"I see from my house by the side of the road,
By the side of the highway of life,
The men that press on with the ardor of hope,
And the men that are faint with strife.
But I turn not away from their smiles nor their tears—
Both parts of an infinite plan;
Let me live in a house by the side of the road,
And be a friend to man!

"I know there are brook-gladdened meadows ahead,
And mountains of wearisome height,
And the road passes on through the long afternoon,
And stretches away to the night.
But still I rejoice when the travelers rejoice,
And weep with the strangers that moan,
Nor live in my house by the side of the road,
Like a man that dwells alone.

"Let me live in a house by the side of the road,
Where the race of men go by;
They are good, they are bad, they are weak, they are strong,
Wise, foolish, and so am I.
Then why should I sit in a scorner's seat,
Or hurl a cynic's ban?
Let me live in a house by the side of the road,
And be a friend to man!"

URTICARIA.*

By Norman T. Kirk, M.D.,
Assistant Resident Physician in University Hospital.

Synonyms.—Hives, nettlerash.

Classified as angioneurosis.

Definition.—Urticaria is an anaphylactic manifestation produced in a sensitized subject by certain specific toxic proteids or chemicals, characterized by lesions of the skin or mucous membranes, evanescent, whitish, pinkish or reddish elevations or wheals, variable as to size and shape, attended by itching, stinging and burning sensations.

Etiology.—The causes of the various urticarial diseases have been divided into three heads—predisposing, internal, external.

Predisposing.—Sex—More frequent in female. Age—early childhood and middle adult life. Family history frequently shows gouty, rheumatic, neuro-arthritic, asthmatic and neurotic taints. Functional and organic diseases, especially of the ovaries, uterus and nervous system are frequently seen. It is often associated with jaundice, gout, rheumatism, purpura, and occasionally co-exists with albuminuria and glycosuria.

Among the *internal* causes, the condition appears after the ingestion of certain foods, especially shellfish, as clams, oysters, lobster, shrimp; also pork, sausage, almonds, cucumbers, strawberries, tomatoes, mushrooms, and even at times after milk and butter. *Drugs* frequently produce the condition, as copaiba, cubeb, chloral, turpentine, salicylates, quinine, opium, the iodids and many of the coal-tar products.

It is frequently seen after the use of antitoxins, vaccines and the Pasteur treatment for rabies.

Emotional or psychic causes, such as anger, fright or sudden grief, seem to excite an outbreak.

Among the *external* causes are irritants such as the sting of the nettle, jellyfish, wasp or caterpillars; and occurs in oyster shuckers and has been known to occur in sensitized persons by application of egg-white to the skin. All of the above have been seen in clinical observation. Stelwagon says there are many causes, but a peculiar individual predisposition is necessary, inasmuch as the same cause may not produce the eruption in different individuals.

Along this line more recent work and thought has brought out the hypothesis, and some experimental work has been done to show that urticaria is an anaphylactic phenomenon, closely allied to asthma, and is caused by certain specific proteids; either animal of vegetable in origin, acting as a toxin to those subjects which have been sentitized to that particular proteid. An urticarial rash is frequently seen accompanying or is one of the symptoms of an anaphylaxis following a second injection of an antitoxin in the so-called serum poisoning. The condition occurred in a fellow-classmate after the course of treatment for rabies.

Experimental work showed that serum, taken from a man who for two years after eating a sausage suffered from an immediate eruption of nettlerash whenever he ate pig meat, injected into a guinea pig excited immediately an extremely clear anaphylaxis with regard to pigs' serum.

It would seem, then, that these phenomena of hypersusceptibility to certain definite proteids

*Read before University of Maryland Medical Society, February 21, 1911.

may be congenital, acquired or inherited; that these proteids may be absorbed from the food in the digestive tract through the circulation, olfactory tract or by injections, and is always a specific condition. Persons sensitized to crab are not susceptible to berries, or vice versa. The causes mentioned above and grouped as internal and external contain the specific proteids.

Pathology.—The condition is an angioneurosis, the lesions which are found on the skin being primarily at least due to vasomotor disturbances, brought about by the action of the toxic proteids. Barthilemy believes dermatographism to be due to a toxic vasomotor dermatoneurosis.

The urticarial lesions are due to dilatation, following spasm, of the arterioles, resulting in effusion with migration of leukocytes. This condition causes pressure on the central portion, bringing about paleness, which was preceded by pinkness and redness, the darker tint on the periphery and size and shape of the lesions being due to the blood, which has been pressed backward, and the depth of the involvement.

There seems to be an increase in the secretion of lymph, as well as a paralysis of the vessel walls. In the ordinary forms only the superficial layers are involved, while in urticaria gigans the whole thickness is involved, and in the edematous variety infiltration occurs in the loose meshes of the subcutaneous areolar tissues. The pathological anatomy of a wheal shows it to be more or less of a firm elevation of a circumscribed or somewhat diffuse collection of semifluid material, especially limited to the corium, which has been shown by Dr. T. C. Gilchrist to be the seat of an acute inflammatory change. The blood vessels, especially around the sweat ducts, are enlarged, contain and are surrounded by a large number of polynuclear leukocytes, while the lymph spaces contain a granular debris. Mast cells are found in the corium. The epidermis is not involved.

Symptoms.—The urticarial eruptions are erythematous in character, usually come on suddenly, may be preceded by burning or itching and consist of scanty or profuse eruption of pea or bean-sized elevations, linear streaks or small or large irregular patches, or admixtures of these forms. The distribution may be localized or general. The outbreak may be preceded or accompanied by gastrointestinal symptoms, febrile action at times in acute, severe cases, or none of these may occur. The lesions are fungacious in character, disappearing and reappearing in the most capricious manner. They are firm to the touch, and vary in color; pinkish or reddish, with white central portions.

The subjective symptoms are usually quite marked, consisting of stinging, intense burning or itching sensations. These may last from a few minutes to half a day, disappearing only to reappear again. The intervening skin is normal. If the lesions persist for several days or a week, condition is known as urticaria persistens.

Ill-defined puffiness of the hands and feet occurs at times with above subjective symptoms.

During the outbreak it is usually possible by drawing a pencil somewhat firmly over the surface to bring out linear wheels. This will remain from a few minutes to several hours; condition is known as urticaria factitia or dermatographism.

The eruption is not always confined to the external surfaces, but the mucous membranes of the mouth, throat, larynx, or even intestines, may be involved.

Numerous forms of lesions exist, as giant urticaria or acute circumscribed edema, which is a localized edema, occurring in the loose subcutaneous tissues around the mouth, eyelids, ears and scrotum, and may be free from subjective symptoms, coming on rapidly, lasting for a day or so, to disappear again.

Urticaria may be acute or chronic, usually the former, lasting from a few hours to several days. Periods between attacks vary, depending upon the exposure to the etiological factor. The chronic form—urticaria persistens—has the same features as acute, save the duration is longer, condition remaining for days and weeks with marked suffering in general health of the patient, due to worry, etc. Several other forms exist.

Diagnosis.—Is usually easy from the distribution and subjective symptoms, their evanescent nature and dermatographism, which is usually present.

Prognosis.—The acute disease is of short duration, disappearing spontaneously or as a result of treatment in a few hours or several days. It has tendency to recur when person is exposed to the etiological cause. The prognosis of the chronic

form is to be guarded until the causing toxin can be found.

Treatment.—The prophylactic treatment consists in finding the specific toxin to which the patient is sensitized. Remove this from his diet if it be found in his food and the attack will not recur.

To relieve the condition we should aim to first get rid of the toxin by free purgation and elimination, and put the patient on a light diet for a few days. Give antacid remedies internally, as sodium bicarb., salicylates, etc. *Ichthyol* in ascending doses is recommended by some; quinine, atropin and coal-tar products often do good. For the local condition give sodium bicarb. bath, soothing ointments or wash, as carbolic ointment, calomine lotion, etc.

The chronic form is the most obstinate. Predisposing factors, as internal or ovarian trouble, neurotic and gouty disturbances, diabetes and nephritis, should be sought for, treated or removed if possible.

MORTON'S TOE.

By T. Gay Whims, Senior Medical Student, and Nathan Winslow, M.D.

The disease takes its name from Dr. Thomas G. Morton of Philadelphia, who first described it, and is characterized by acute cramping pains at the base of the third or fourth toes. It occurs in nervous persons, most frequently in women; children are very rarely affected. Heredity may play some role in the causation of the disease.

The exciting cause comes from the plantar nerves being pinched or pressed upon by the heads of the metatarsal bones, the normal relation between these having been for some cause disturbed. This disturbance in the relation of the metatarsal bones is usually brought about by wearing shoes which are too tight. The condition is often associated with flat foot.

The pain usually comes on suddenly while the patient is walking, and it may be so severe that she has to sit down at once and remove her shoes. The pain, which is sharp and cramping, is in this way partly relieved. Rubbing also helps to alleviate it. After the acute attack a sense of soreness and numbness remains. The pain can be produced by squeezing the foot in the hand. The attacks tend to become more frequent and severe. Plantar flexion of the toes is usually and dorsal flexion sometimes limited. The pain is often accompanied by a snapping of the metatarsal bones, and this has been known to be the chief symptom in this condition. The arch of the foot may be somewhat lowered, the front of the foot may be flattened with a depression on its dorsum, over the middle metatarsals, or it is possible for the foot to be normal in shape. The characteristic symptoms make the diagnosis easy.

Mild cases in which there are no deformities of the foot may be cured by employing massage and by wearing of properly fitting shoes. In cases with deformity it is usually necessary to employ braces or plates of such a shape as to overcome the deformity. The gastrocnemius muscle is sometimes contracted, and should in such a case be stretched. In severe cases removal of the distal end of one of the metatarsals, and even resection of the metatarso-phalangeal articulation, have been resorted to. The cure from these operative measures may not be permanent, however. Some cases are reported to have been cured by excising a portion of the superficial branch of the external plantar nerve.

Report of Case.—Miss E. S. W., aged 24, white, came under observation two years ago for severe pain in fourth metatarso-phalangeal articulation. The pain was cramp-like, extremely excruciating in character and came on suddenly while walking. It was only relieved by removal of shoe and rubbing. With time the pain gradually became worse and occurred at more frequent intervals. The joint was sore on pressure and was sore to the touch for some time after the attack. The dorsal surface of the foot was slightly swollen and red.

A felt pad was placed under the joint to no avail, so operation was advised, which was consented to.

On the 14th of May, 1910, the patient was anesthetized, the operative area properly cleansed, and a dorsal incision made directly over the joint and carried down to the bones to the side of the extensor tendons. The head of the fourth metatarsal and the proximal end of the fourth phalangeal bone were excised, and a few strands of silkworm gut were inserted as a drain. These were removed in two days and the wound allowed to close by primary intention. The patient was about in a week, and since then has had no return of the

symptoms. It is yet too early to prognosticate the ultimate result, but after a year and five months of continuous use, with no recurrence of pain, we may reasonably assume she is permanently cured.

DIRECT INGUINAL HERNIA.

By Jas. J. Edelen,
Senior Medical Student.

There are two forms of inguinal hernia, the oblique and the direct. The oblique inguinal hernia is of very frequent occurrence and occurs as both a congenital and an acquired malady. On the other hand, direct inguinal hernia is a comparatively rare affection, though perhaps it occurs more frequently than is generally thought to be the case. It probably occurs in about 10 per cent. of all cases of inguinal hernia in the adult. It may possibly be a congenital affection, but, if so, this occurs so very infrequently that it may be regarded as an acquired disease in practically all cases. Males are much more frequently the subjects of this condition than females. Whilst it has been observed in childhood in a few cases, it is so infrequent during that period of life that in upward of 2200 operations in children at the New York Hospital for Ruptured and Crippled, reported by Dr. William B. Coley, there was none for direct inguinal hernia.

Anatomy.—Direct inguinal hernia derives its name from the fact that it does not traverse the inguinal canal, but protrudes directly through the abdominal wall at the external abdominal ring, and does not descend into the scrotum. The hernia escapes from the abdominal cavity at Hesselbach's triangle, a space bounded internally by the outer edge of the rectus muscle, externally by the deep epigastric artery, and below by Poupart's ligament. The intestine either pushes the conjoined tendon in front of it, or passes through a slit in this structure or slips to the outer side of the conjoined tendon. The epigastric artery invariably lies to the outer side of a direct inguinal hernia, and the relation of the artery to the neck of the hernical sac determines whether we have to deal with an oblique or direct inguinal rupture. If the sac is on the outer side of the deep epigastric vessels it must be an oblique form of hernia; if it is on the inner side of these vessels it is a direct hernia. The coverings of direct rupture differ somewhat from those of the oblique, being skin and superficial fascia, intercolumnar fascia, conjoined tendon, transversalis fascia and peritoneum. The cord is usually situated in front of the hernia or to its outer side, and not behind it as in the indirect variety.

Symptoms.—There are the usual signs of hernia, but the lump develops rather slowly and does not descend into the scrotum. The swelling is rather globular in shape and is situated closer to the penis than the oblique variety. The finger can be pushed directly backwards into the abdominal cavity and does not traverse the inguinal canal. Too much reliance, however, cannot be placed in the physical characteristics of this hernia, as frequently one is mistaken in the diagnosis, or the diagnosis is only made after the incision of the tissues. Sometimes the bladder also protrudes in connection with direct hernia, and one should always bear in mind the possibility of this complication, and in operating for the cure of this form of hernia any abnormal appearance of the sac or surrounding tissues should excite suspicion and cause especial care not to injure this viscus. When the bladder is incised it must be sewed up and a drain placed in the lower end of the wound. A direct inguinal hernia is liable to become strangulated, but apparently this does not often occur.

Treatment.—In some cases it may be proper to wear a truss, but this is usually very unsatisfactory. In most instances a radical operation should be performed. The best method is Bassini's, but the results are not so good as in the oblique variety. Coley gives 85 per cent. of cures in direct inguinal hernia. The occurrence this session of several cases of this form of hernia in the service of Professor Randolph Winslow has prompted the writing of this brief essay. In oblique inguinal hernia Professor Winslow usually employs Ferguson's method; that is, the spermatic cord is buried beneath the internal oblique muscle. In the direct inguinal hernia he performs Bassini's operation, and it is better to place the cord between the skin and the aponeurosis of the external oblique muscle, and to suture the external abdominal ring tightly.

ADDRESS.*

By George R. Gaither.

It is a difficult task in addressing the alumni of this old University of Maryland to suggest any new or interesting train of thought for your consideration. In the splendid training which the college graduates now enjoy, and in the present infinitely varied means for diffusing intelligence and ideas throughout the land, it is practically impossible for any speaker in an evening's address to portray the modern tendencies of the intellectual thought of the day or the varied achievements of our complex civilization in the few minutes which I shall trespass upon your attention. It is my purpose, if possible, to call your attention not to these positive requirements, but to some of the factors in man's development which in my mind are most important, and yet which are being largely neglected in the mad rush of modern development and the complex conditions of modern civilization. The old division of the powers of mankind into three great agencies seems as vital to me today as in every age of man's life upon this earth. The intellect, the will and the emotional or spiritual part of man are the forces through which his development and progress have been created. In the wondrous development of all channels and institutions for investigation, education and original research of the present age there is but little danger that the intellect of man will not receive all of the power, energy and training which has been so essential to the splendid development of the intellectual powers, and the "rule of reason" would seem destined to perpetual existence. Likewise, in the great domain of action the will of man finds expression in the infinitely varied products of man's genius and effort which surround us on every side and excite our wonder and admiration. The age which has produced such material results can never want for the stimulus which directs and moulds man's actions. The danger is rather that the creator will be lost in the creation; that the triumphal car of invention and combination for the benefit of the great mass of humanity will operate like some human juggernaut in crushing out the inner life of the individual. The eternal restless tide of modern civilization seems to sweep all forces before it in its resistless might.

On the other hand, what has been the effect of these great agencies in the development of those qualities which make the charm of each individual life, and whose existence in the ages which have passed has brightened and glorified the pages of history? Is there any force in the universe comparable to man's spirit, and to the many manifestations of its infinite power, which have broadened the horizon of humanity and lifted it beyond its earthly environment? Is not the age of machinery and reason calculated to stifle rather than to develop these momentous forces which exist in each individual, and whose united strength has made the progress of the world? Is there no place for the development of the finer qualities of mankind in a civilization such as ours? Who of us has not thrilled at the enthusiasm and self-sacrifice which swept over Europe at the time of the Crusades? Who has not longed for the qualities which made the chivalry and romance of the Middle Ages? Who has not gloried in the ceaseless zeal, heroic endeavor and unselfish devotion of the army of martyrs and patriots of all the ages who have struggled and fought for the supremacy of human rights and the emancipation of suffering races from tryanny and oppression? Are not the qualities of patriotism, self-sacrifice, heroism, gentleness, courage and faithfulness as necessary for the welfare of mankind in this modern age as the material and intellectual development which we have acquired? Nay, are they not more so if we are truly to enjoy the blessings of civilization? May the day speedily come in our national life when the qualities which make the man will be of more solicitude to our people than the protection of our material possessions or the distribution of our great productions. Already there are bright signs of a new era and a new epoch in our national life. In the future I trust and believe that we shall establish new standards of life and living; that health will be deemed of greater value than wealth; that happiness will be paramount to mere physical comfort, and that mankind will once more realize that his world is a "stepping-stone to higher things," and not a mere arena of senseless struggle or a stage setting for an empty play. And with the true development of the spirit of man, supplementing his matchless intellect, will come the revelation of the mysteries of an

*Delivered before the Annual Smoker of the Graduating Classes and the General Alumni Association of the University of Maryland, June 1, 1911, at the Hall of the Medical and Chirurgical Faculty of Maryland.

unseen world of spirit—one which surrounds us now on every side.

"But while this muddy vesture of decay
Doth grossly close us in, we cannot see it."

A REPORT OF THE PROGRESS OF THE NEW MATERNITY.

By L. E. Neale, M.D., LL.D., Professor of Obstetrics; E. H. Kloman, Ph.G., M.D., Associate in Obstetrics; W. L. Byerly, M. D., L. H. Douglas, M.D., S. E. Lee, M.D., Resident Physicians.

The old Maternity, situated at 622 West Lombard street, has long served the purpose as a free lying-in hospital, but until recently we have not been able to accommodate private obstetrical cases in the maternity department. On the first day of April, 1910, the new quarters were completed in the general hospital, occupying the wing which had previously been the nurses' home and had been remodeled into a modern maternity. The chief fault with the old building was one of the marked features of improvement in the new one—*i. e.,* the accommodations for private patients. The new Maternity has a private waiting ward, as well as a private puerperal ward. Each contains six to seven beds. These wards are modern in all respects and are situated in a part of the hospital where the patients are out of contact with those in the general hospital. Across the hall from the wards are the private rooms that are suited for those desiring better accommodations. These rooms are supplied with ideal furniture for the lying-in room. On the same floor is a private operating and delivery room, nursery, bath, diet kitchen and modern sterilizing-room. This whole floor is devoted to private patients. On the first floor above are two large wards for the free patients, one for colored and one for white patients. These wards are also subdivided into waiting and puerperal wards. This floor has also its own operating and delivery room. The nursery is one of the great improvements. Instead of using the large beds to place infants upon, we now have separate beds. Each infant has its own separate white enamel crib, and this makes isolation practically a constant feature. The nursery also possesses a modern incubator, where many of the premature infants are raised which otherwise would seem impossible but for this modern asset. The resident staff has recently been increased to three instead of two, and we have now one senior and two junior residents. We also have a graduate nurse to superintend and train those nurses taking their obstetrical training. As a result of all this modern equipment it gives us great pleasure to make a very favorable report after one year's trial.

The number of cases treated for the year ending June, 1911, has just doubled those treated the previous year, the greatest part of this increase being with the private patients. There were four times as many private cases this year as the year previous. This department now treats all abortions and miscarriages, which has heretofore been out of the question, due to lack of room and accommodations.

The free out-patient department likewise increased, as you will see below. How has this increase in the out-patient department helped our free clinic? It has been our desire to have the abnormal and operative cases under our direct care. We aim to accomplish this by having our residents go into the field and select such cases that require hospital treatment and bring them into the clinic before labor begins.

This has given the student a better chance to see operative work, has given the residents better opportunity to do operative work, and has fitted the clinic with excellent material for post-graduate work. The out-patient department has grown markedly. This is in part due to the care which the students are required to use in their work with free cases and frequent visits by the resident physicians. The students are required to make preliminary examinations, to keep in touch with and to report any abnormal case.

This gives them excellent training in palpation, and they are taught to make a diagnosis by external palpation, hence lessening the risks for infections.

In the present graduating class each man will average 40 cases which he has seen and been associated with, and of these he will average 15 which he has personally attended in the out-patient department.

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, JUNE 15, 1911.

SOWING AND REAPING.

"Behold, a sower went forth to sow; and when he sowed, some seeds fell by the wayside, and some fell upon stony places, but others fell into good ground, and brought forth fruit."

We have been sowing seed, good hard No. 1 wheat. The work has been somewhat interrupted by the examinations and other duties incident to the closing weeks of the session, but the seed has still been scattered. Doubtless much that has been sown has fallen by the wayside or upon stony hearts, but some has brought forth fruit. It is the unexpected that usually happens. This is true in almost all the avocations and contingencies of life. It has proven true in the short effort we have been making to excite interest and raise money for the endowment of the pathological department. Those best able to help us, and those whose loyalty should be strongest, have not responded to our cry as yet, while from far-off California, from the Red River of the North, from South Carolina, from the sturdy old North State, and from the mighty city on Manhattan, as well as from the progressive State of West Virginia, responses to our appeals have been received. We thank these friends, as well as those nearer at hand, who have encouraged us with their approval and helped us with their means. We shall continue our efforts, but we beg our alumni not to leave this matter entirely in the hands of a few of us, but let each one constitute himself a committee to push along the work. The writer would like to see an alumni chair of pathology, endowed by the alumni and to a large extent controlled by them. Let us continue to sow the seed, for we believe "that in due season we shall reap, if we faint not."

MAKE YOUR WILLS.

Only two things are said to be certain in this world—death and taxation. If one has been fortunate enough to acquire property, the taxgatherer will certainly find him out; hence it is not necessary to be too eager to hunt him up. He will come soon enough. Another unsought visitor frequently seeks us and takes all that we have. Next to laying up treasure for our own eternal use, "where neither moth nor rust doth corrupt, and where thieves do not break through nor steal," is the duty of so disposing of our property that it may be devoted to the best use possible. If one has a family, it is his duty and privilege to so arrange his affairs that those who are dependent on him shall be adequately provided for. He should, therefore, make his will, in order that his wishes may be carried out. Particularly is it important for the man of small means to make his will, leaving all his property to his wife, as in this manner the estate is kept intact and the wife is better able to provide for the family, if there are children. Another matter should also be kept in mind by the alumni of the University of Maryland, and that is the privilege of leaving a bequest, large or small, to the medical school for such purpose as may seem desirable to the dônor. If our alumni would remember their alma mater in their wills they would rest with the assurance that some of their labor will not have been in vain.

WATCH THE FUND.

The following contributions have been made to the endowment fund of the department of Pathology to June 1:

Robinson bequest	$5,000 00
Dr. Hugh Hampton Young, J. H. U.	100 00
Dr. Gideon Timberlake	25 00
Mr. H. P. Ohm	10 00
Dr. Samuel W. Moore, D.D.S.	25 00
Dr. John J. R. Krozer, 1848	50 00
Dr. Joseph T. Smith, 1872	10 00
Dr. W. J. Young, 1872	25 00
Dr. Thomas A. Ashby, 1873	100 00
Dr. David W. Bulluck, 1873	100 00
Dr. Robert Gerstell, 1873	5 00
Dr. Randolph Winslow, 1873	100 00
Dr. H. T. Harrison, 1874	5 00
Dr. J. M. Hundley, 1882	250 00
Dr. Henry Chandlee, 1882	10 00
Dr. B. Merrill Hopkinson, 1885	25 00

Dr. H. C. Reamer, 1885	10 00
Dr. C. W. McElfresh, 1889	100 00
Dr. Harry Adler, 1895	100 00
Dr. Joseph L. Hirsh, 1895	50 00
Dr. R. W. Sturgis, 1896	2 00
Dr. Louis W. Armstrong, 1900	10 00
Dr. Salvatore Demarco, 1900	50 00
Dr. M. S. Pearre, 1900	5 00
Dr. Nathan Winslow, 1901	50 00
Dr. A. M. Shipley, 1902	250 00
Dr. Hugh W. Brent, 1903	25 00
Dr. Robert P. Bay, 1905	100 00
Dr. S. J. Meltzer, LL.D., New York	10 00
	$6,602 00

CHANGES IN THE MEDICAL FACULTY.

At a recent meeting of the Medical Faculty Dr. Harry Adler, Clinical Professor of Medicine and Director of the Clinical Laboratory, was elected Professor of Therapeutics and Clinical Medicine; Dr. Gordon Wilson, now Associate Professor of Practice of Medicine, was made Professor of Clinical Medicine, and Dr. Joseph Gichner was made Clinical Professor of Medicine and Associate Professor of Physical Therapeutics. We cannot commend these promotions too highly, and believe they will meet with the approval of everyone concerned in the welfare of the University.

Dr. Adler is a B.A. of the Johns Hopkins University and an M.D. of the University of Maryland, class of 1895. Since graduating he has been continuously associated with its teaching force. He is a tireless worker and a teacher of proven ability.

Dr. Gordon Wilson is an M.D. of the University of Virginia and an ex-assistant resident physician of Johns Hopkins Hospital. He has been associated with the Department of Medicine of the University since 1903, and has given general satisfaction as a teacher alike to faculty and students.

Dr. Joseph E. Gichner, class of 1890, has had added to the duties pertaining to the Chair of Clinical Medicine those of Physical Therapeutics. The latter is a much-needed course, as physical remedies are gaining in importance daily. Dr. Gichner's knowledge of the physical agents is such as to warrant the expectation of a very interesting as well as beneficial series of lectures.

DISPENSARY REPORT.

DISPENSARY CASES, APRIL 1, 1910, TO APRIL 1, 1911.

Department.	New.	Old.	Total.
Surgical (1)	1,052	5,247	6,899
Medical (2)	1,225	2,896	4,121
Genito Urinary (3)	681	3,182	3,863
Nervous (4)	269	1,658	1,927
Stomach (4)	520	1,407	1,927
Eye and Ear (5)	687	1,147	1,834
Women (6)	680	1,131	1,811
Throat (8)	652	924	1,576
Lung (7)	805	928	1,733
Children (9)	583	733	1,316
Skin (10)	351	523	874
Orthopedic (11)	47	236	283
Rectal (12)	36	44	80
	8,188	20,056	28,244

Total new cases	8,188
Old cases	20,056
Grand total	28,244
Grand total, 1909-1910	25,881

JOHN HOUFF, M.D.,
Dispensary Physician.

THE ONE HUNDRED AND FOURTH ANNUAL COMMENCEMENT.

The annual commencement of the University of Maryland was held at the Lyric Thursday afternoon, June 1, 1911, at 4 o'clock. The order of exercises was as follows:

Overture—"Fest" ..... Leutner
Selection—"Pink Lady" ..... Caryl
Waltz—"Spring Maid" ..... Caryl
Music—March, "Aida" ..... Verdi
Prayer by Rev. Oliver Huckel, D.D.
Music—"Meditation from "Thais" ..... Massenet
Address to the Graduates, Harvey W. Wiley, Ph.D., LL.D., Chief of the Bureau of Chemistry, Department of Agriculture, Washington, D. C.
Music—March, "Patriotic" ..... Rosslyn
Conferring of Degrees by Bernard Carter, LL.D., Provost of the University.
Candidates for the Degrees "Bachelor of Arts" and Bachelor of Sciences" presented by the Dean of the Faculty of Arts and Sciences.
Candidates for the Degree "Doctor of Medicine" presented by the Dean of the Faculty of Physic.
Candidates for the Degree "Bachelor of Laws" presented by the Dean of the Faculty of Law.
Candidates for the Degree "Doctor of Dental Surgery" presented by the Dean of the Faculty of Dentistry.

Candidates for the Degree "Doctor of Pharmacy" presented by the Dean of the Faculty of Pharmacy.
Conferring of Honorary Degrees.
Presentation of a Bust of the late Prof. James H. Harris, M.D., D.D.S.
Music—"Pas de Echarpes".....Chaminade
Award of Prizes.
Music—March, "Stars and Stripes".....Sousa

The address of Dr. Harvey W. Wiley appears on page 61 of this issue of THE BULLETIN. There were 203 graduates. They were presented by the deans of their respective departments, and were classified as follows:

Bachelor of Arts	16
Bachelor of Science	2
Doctor of Medicine	70
Bachelor of Laws	50
Doctor of Dental Surgery	43
Doctor of Pharmacy	22

Students who received degrees are:

BACHELOR OF ARTS.

Rowland K. Adams.
L. Claude Bailey.
Clark Ferguson Brown.
E. Foster Davis.
S. Carl Drake.
Henry Lee Johnson.
Wilbur L. Koontz.
J. Eccleston Marsh.
John L. Morris.
Robert Graham Moss.
Eugene M. Owen.
Thomas Parran, Jr.
Emerson B. Roberts.
George E. Rullman.
William Stanley.
Herbert Douglas Taylor.

BACHELOR OF SCIENCE.

John Frederick Koenig.
William Roland Vansant.

DOCTOR OF MEDICINE.

Edward Garrett Altvater, Maryland.
Burt Jacob Asper, Pennsylvania.
Henry Benedict Athey, Maryland.
Walter Compton Bacon, Maryland.
Mordecai Lee Barefoot, North Carolina.
Frederick Lewis Blair, Rhode Island.
Buehler Shoup Boyer, Maryland.
Archie Eugene Brown, South Carolina.
Ernest S. Bullock, North Carolina.
William Luther Byerly, Maryland.
Samuel Hopkins Cassidy, Tennessee.
Belton Drafts Caughman, South Carolina.
Henry Dickinson Causey, Delaware.
Herbert Augustus Codington, Georgia.
James Erwin Diehl, Pennsylvania.
Richard C. Dodson, Maryland.
Louis Harriman Douglass, Maryland.
Charles L. Dries, Pennsylvania.
William Joseph Durkin, New York.
James Joseph Edelen, Maryland.
Joseph Benjamin Edwards, South Carolina.
Otto Fisher, Virginia.
Jacob Jesse Greengrass, New Jersey.
Isidore Isaac Hirschman, Maryland.
Abraham Lewis Hornstein, Maryland.
Grover Latham Howard, Virginia.
John Thomas Howell, North Carolina.
Raymond Garrison Hussey, North Carolina.
Jose E. Igartua de Jesus, Porto Rico.
Kenneth B. Jones, Maryland.
Charles Hutchison Keesor, West Virginia.
Charles Edward Kernodle, North Carolina.
Charles R. Law, Jr., Maryland.
Samuel Engle Lee, Maryland.
Frank Levinson, Maryland.
Willis Linn, New York.
Paul Pressly McCain, South Carolina.
Lawrence E. McDaniel, South Carolina.
Isaac Michel Macks, Maryland.
Manuel Eulalio Mallen, Santo Domingo.
William Clinton Marett, South Carolina.
George Yellott Massenburg, Maryland.
John Guirley Missildine, Pennsylvania.
Allen T. Moulton, Massachusetts.
Adolph Mulstein, New York.
Walter Saulsbury Niblett, Delaware.
Elijah Emera Nichols, Delaware.
Vernon Llewellyn Oler, Maryland.
John Ostro, Delaware.
James Earle Quigley, Pennsylvania.
Themistocles Julian Ramirez, Porto Rico.
Stanley H. Rynkiewicz, Pennsylvania.
Harry Bagenstose Schaeffer, Pennsylvania.
Charles Louis Schmidt, Maryland.
Dallas C. Speas, North Carolina.
Louis Stinson, Mississippi.
Joseph Stomel, Pennsylvania.
Emmett O'Brien Taylor, South Carolina.
Ralph Leland Taylor, Georgia.
Joseph Enloe Thomas, South Carolina.
Grafton Dent Townshend, Maryland.
Ralph J. Vreeland, New Jersey.
Louis Kyle Walker, North Carolina.
Charles Stuart Wallace, Oklahoma.
Sydney Wallenstein, New York.
Charles Alexander Waters, Maryland.
Albert G. Webster, Maryland.
Thomas Gay Whims, West Virginia.
Java Cleveland Wilkins, North Carolina.
Richard Lloyd Williams, Pennsylvania.

PRIZEMAN.

University prize, gold medal, Burt Jacob Asper.

Certificates of Honor.

Charles Louis Schmidt, Thomas Gay Whims,
Joseph Benjamin Edwards, Isaac Michel Macks,
Themistocles Julian Ramirez, Charles Hutchison Keesor.
Jose E. Igartua.

BACHELOR OF LAWS.

Chester Alan Arthur Albrecht,
Joseph Anthony Ambrose,
James Conner Lee Anderson,
Oswald Athanase Beaulieu,
Charles Brown Bosley,
Charles Henry Buck,
William Winfield Scott Causey,
John Leslie Cornell,
James McGrath Crockett,
Arthur Wilson Dowell,
George Eckhardt,
Thomas Joseph Fraley,
Harry Freedman,
Lee Eyster Gilbert,
John Stewart Glen,
Moses Henry Goldstone,
Cyril Hansell,
Edwin Hanson Webster Harlan,
Louis Joseph Jira,
Walter Eugene Keene,
Dave Benjamin Kirsner,
Anthony Walter Kraus,
Philip Edward Lamb,
Stephen Wells Leitch,
Jacob Levine,
Edgar Henry McBride,
Cyprian William McSherry,
Titus Lyde Mason, Jr.,
Charles McCurdy Mathias,
James S. Clarke Murphy,
Clapham Murray, Jr.,
Joseph Nathanson,
Elbert Ray Nuttle,
George Brauer Oehm,
Peter Peck,
Saul Praeger,
Hannibal Hamlin Reid,
George Albert Rossing,
Herbert Alger Schloss,
Harry Lamar Smith,
Warren Adams Stewart,
Philip Louis Skyes,
Arthur Le Mar Vickers,
Raphael Walter,
Daniel Lloyd Wilkinson,
John Wirt Wilmer,
Harvey Hill Wilson,
Eli Gardner Ziegler,
Marshall Frederick Lahm Zeigler,
Henry Zoller, Jr.

DOCTOR OF DENTAL SURGERY.

Lloyd Mehring Basehoar, Pennsylvania.
Lawrence Welling Bonnoitt, Virginia.
Daniel Bratton, Maryland.
Rhodes Burrows, Connecticut.
Lucas Angel Cambo-Ruiz, Cuba.
Thomas John Claggett, Maryland.
William Francis Courtney, Connecticut.
William Lee Davidson, South Carolina.
John Gleason Donnelly, Jr., New Jersey.
Solomon M. Feldstein, New York.
Howard Morton Finch, Connecticut.
Leo Freiburger, Austria.
Henry Andrew Folsom, Vermont.
Risden Bennett Gaddy, North Carolina.
Samuel Hawthorne Gluckman, New Jersey.
Howard Crosby Greene, Connecticut.
Sherman Jenkins Hamilton, New York.
Seaborn James Hargrove, Jr., Georgia.
A. Douglas S. Harrower, Virginia.
Daniel Edward Healey, New York.
William Stuart Hart Heermans, Jr., New York.
Lowell Philip Henneberger, Pennsylvania.
Benjamin Frederick Herman, Connecticut.
Daniel Pinkney High, Jr., North Carolina.
Adolph John Hoffmann, New Jersey.
Samuel Boss Johnston, Virginia.
M. Lafayette Justice, North Carolina.
Alfredo E. Justiz-Maspons, Cuba.
Gabriel K. Jureidini, Egypt.
Carter Inskeep Long, West Virginia.
Arthur Franklin Lynch, Rhode Island.
Henry Martin, Connecticut.
Anibal F. L. Montero y Diaz, Cuba.
Taylor Phifer Nisbet, South Carolina.
Alexander Horn Paterson, Pennsylvania.
Samuel Roth, Maryland.
Robah Harrison Shore, North Carolina.
Robert Thomas Skelton, New York.
Allen G. Thurman Twigg, Maryland.
Randolph M. Urmson, Pennsylvania.
David Clark White, Louisiana.
Charles E. Wingo, Jr., Maryland.
Olin Harold Youngs, Connecticut.

PRIZEMAN.

University prize, gold medal, Alexander Horn Paterson.

Honorable Mention.

Henry Andrew Folsom.

DOCTOR OF PHARMACY.

Filiberto Artigiani, Italy.
Noel Sifly Avinger, South Carolina.
Flora Blattstein, Roumania.
Carvilla Brian Boyd, Pennsylvania.
Leon Dettelbach, Maryland.
Paul Francis Flynn, Connecticut.
Frederic Garrison, New York.
Aloyuise Hergenrother, Maryland.
Otis Leroy Johnson, South Carolina.
Lawrence Regis Laroque, Maryland.
Harry Clarendon Lewis, Maryland.
Nicholas Thomas Lombard, Italy.
Clifford Otto Miller, Ohio.
Carl Wilhelm Oertel, Maryland.
R. Gorman Phelps, Maryland.
Thomas Ellsworth Ragland, Maryland.
James Edwin Stokes, South Carolina.
Joseph Samuel Sandler, Maryland.
Powell Parker Towers, Maryland.
George Harry Waltz, Maryland.
William John Wannamaker, South Carolina.
John C. Woodland, Maryland.

PRIZEMAN.

Gold medal for general excellence, Clifford Otto Miller.

Certificates of Honor in Order of Merit.

Filiberto Artigiani,
Paul Francis Flynn.

SPECIAL PRIZES.

Simon medal for superior work in chemistry, Clifford Otto Miller.

Gold medal for superior work in pharmacy, Thomas Ellsworth Ragland.

Alumni medal for superior work in vegetable histology, Clifford Otto Miller.

Distinctions in the Junior Class.

Gold medal for general excellence, Herman Dietel, Jr.

Honorable Mention in Order of Merit.

Sidney J. Brown, Lee Hodges,
Henry F. Hein, T. Stanley Smith,
Ethan O. Frierson.

ITEMS

By special request we give our record of the class of 1897 as follows:

G. W. Banks, Shepherdstown, W. Va.

Harry Lewis Baptist, Ivy, Va.

Bernard Barrow, Barrows' Store, Va.

Henry Thomas Batts, died July 10, 1902.

A. E. Bell, Mooresville, N. C.

William Newbold Bispham, Major, U. S. A.

Peter P. Causey, Suffolk, Va.

Harry C. Chappelier, Hughville, Md.

Calvin E. Clay, Martinsburg, W. Va.

Charles Franklin Cooper, Pitts, Ga.

Walter W. Dodson, Laurens, S. C.

Isaac C. Dickson, 3053 West North avenue, Baltimore.

Frederick Dobyns, 110 North Eutaw street, Baltimore, Md.

J. J. Durrett, Fairmont, W. Va.

Osceola Dyer, Franklin, W. Va.

Arey C. Everett, Pegues, N. C.

William E. Fahrney, Timberville, Va.

Percy Roland Fisher, Denton, Md.

Henry M. Fitzhugh, Jr., Westminster, Md.

Charles R. Foutz, Westminster, Md.

Page A. Gibbons, Morgantown, W. Va.

Lucius N. Glenn, Gastonia, N. C.

Samuel Butler Grimes, Roland Park, Md.

Samuel N. Harrell, Tarboro, N. C.

Lurty Noel Harris, Mill Creek, W. Va.

John Ellis Hart, Deep Creek, N. C.

Arthur C. Hearn, 156 Milton avenue, Baltimore.

Timothy O. Heatwole, 2003 North Charles street, Baltimore.

William Isaac Hill, Albemarle, N. C.

James Lee Hopkins, Havre de Grace, Md.

John S. Howkins, 16 East Liberty street, Savannah, Ga.

Peter John, Laurinburg, N. C.

James E. Kerr, Lilesville, N. C.

Jennings M. King, Buckhannon, W. Va.

Samuel Peachy Latane, died May 1, 1910.

George W. Lautenbach, 625 Mosher street, Baltimore.

James D. Love, Jacksonville, Fla.

Carville V. Mace, Rossville, Md.

Charles D. Marchant, Harmony Village, Va.

William R. McCain, Charlotte, N. C.

R. H. McGinnis, Jacksonville, Fla.

L. Wardlaw Miles, Princeton University (not practicing).

J. C. Monmonier, Jr., Hillsdale, Md.

F. Alan G. Murray, Mt. Savage, Md.

T. McL. Northrop, St. Pauls, N. C.

R. Walter Patterson, Clarksburg, W. Va.

Oliver Parker Penning, 1711 St. Paul street, Baltimore.

Walter Stith Philips, Rapidan, Va.

Richard F. Richards, Hampstead, Md.

Compton Reily, 2025 North Charles street, Baltimore (orthopedic specialist).

Robert Conrad Rind, 121 East Madison avenue, Springfield, Ohio.

Oscar Leslie Rogers, Sandersville, Ga.

Sidney G. Sarratt, Union, S. C.

Reverdy Sasscer, Upper Marlboro, Md

Rupert Leroy Savage, Rocky Mount, N. C.

Thomas Littleton Savin, 1349 York road, Baltimore.

Henry Franklin Schamel, Brunswick, Md.

Charles L. Scott, Asheville, N. C.

Gilbert Tyson Smith, Jr., U. S. G. and C. Survey, stationed in Alaska.

Guy Steele, Cambridge, Md.

Charles R. Stevenson, De Lancey, Pa.

William H. Clendenin Teal, died January 28, 1910.

J. Brown Wallace, 322 Hyde Park avenue, Tampa, Fla.

Charles A. Wiest, Stover, Mo.

F. Delaphaine Willis, Newport News, Va.

We are unable to locate the following members of this class: William S. Huggins, Garrett John Landers, W. H. Lippitt, William Matthews, Edwin R. Ramsey, John J. Sullivan and Julius Weinberger. We will thank any of our readers for any information as to their present location or other knowledge concerning them.

Dr. Albert H. Carroll, class of 1907, is at Woods Hole, Mass., and will spend the summer there, working in the physiological and biological laboratories.

Dr. Norman T. Kirk, class of 1910, has been appointed surgeon to the Atlantic Coast Line Railroad, to be located in their hospital at Rocky Mount, N. C.

The University of Maryland Training School for Nurses held its commencement exercises on

Thursday evening, May 11, 1911, at Lehmann's Hall. Rev. A. B. Kinsolving of Old St. Paul's P. E. Church, opened with prayer. The diplomas were conferred by R. Dorsey Coale, Ph.D., dean of the Medical Faculty, and the address to the graduates was made by Dr. Arthur M. Shipley, class of 1902, Professor of Materia Medica and Surgical Pathology. The graduates were Mary Louise Gephart, Maryland; Anne Schooley Grubb, Florida; George Allen Hutton, Maryland; Frances Woodbridge Sprecher, Maryland; Elizabeth Cromwell Patterson, Pennsylvania; Barbara Ellen Stouffer, Maryland; Mary Gertrude Brady, Maryland; Nellie Elizabeth Curtiss, Maryland; Marvel E. Scarff, Maryland; Elizabeth Evelyn Robinson, Maryland; Stella Udore Ricketts, Pennsylvania; Naomi Helland, Maryland; Ivy Irene Kinney, West Virginia; Alva Mae Williams, Maryland; Ruth Elizabeth Berlin, Pennsylvania; Mary Ellen Sullivan, Massachusetts, and Jennie Rockhold Garner, Maryland.

Dr. John C. Hemmeter left June 12 for Woods Hole, Mass., where he has taken a cottage for the season. He will move into his new home on Charles-street boulevard December 1.

The State, a daily paper of Columbia, S. C., publishes the following special from Leesville, S. C., concerning Dr. Luther Allen Riser, class of 1908, in its issue of May 25, 1911:

"Yesterday afternoon, about 6 o'clock, a horse belonging to two fruit-tree agents from Tennessee ran away here. The horse started running on the eastern edge of the town, and came through Main street, hitched to a buggy. At H. F. Hendrix's store the horse turned west, and made directly for a crowd of children who were playing in the street, all unconscious of their danger. Dr. L. A. Riser was sitting in his buggy in front of the Hendrix Hotel, out of danger, but seeing the danger of the children, he jumped in front of the mad animal, in an attempt to turn it out of its course. He did this, but as the animal turned the buggy went over and knocked the young man down. He caught under the buggy and was dragged several yards. Finally the horse broke loose from the buggy, and Dr. Riser was able to get out, with one knee skinned, his head bruised and his left arm broken just above the wrist. There was not another doctor in town at the time, but Drs. Gibson and Timmerman came from Batesburg and set the fracture. The patient is doing well.

"No braver thing than Dr. Riser's action has ever been seen in Leesville. There were about 10 children, all small, on the grass in the park, and the horse was running directly for them. Dr. Riser was in no danger where he was, but he saw that some of the children would be crushed unless he saved them, and he did his best, absolutely regardless of danger to himself. Needless to say, the people whose children were saved by his action will not soon forget him."

Dr. Edgar G. Ballenger, class of 1901, of Atlanta, Ga., has just had published a book entitled "Genito-Urinary Diseases and Syphilis." We wish Dr. Ballenger much success, both with his magazine—the *Journal-Record of Medicine*—and with his book.

Dr. Randolph Winslow, class of 1871, will leave on June 17 for the annual meeting of the American Medical Association at Los Angeles, Cal.

Mrs. Ethel Palmer Clarke, University Hospital Training School for Nurses, class of 1906, has been appointed superintendent of nurses at the University Hospital, succeeding Miss Bell, resigned. Mrs. Clarke is a native of Richmond, and has just resigned as superintendent of the De Soto Hospital, Jacksonville, Fla.

Miss Nettie Flanagan, class of 1902, has resigned as superintendent of St. Luke's Hospital, Spokane, Wash.

Misses E. A. Strohm and P. V. Pleasants, class of 1910, have taken charge of the De Soto Hospital, Jacksonville, Fla.

Misses Vera Wright and M. V. Saulsbury, class of 1909, have taken positions at the Presbyterian Hospital of New Orleans, La.

Miss Mary C. Wiggin, class of 1910, and Miss Nellie F. Ferrel, class of 1905, have joined the nursing corps, U. S. N.

Dr. Walter Van Swearingen (otherwise Sevy), class of 1904, is located at 1703 25th street N. W., Washington, D. C.

In a recent letter to Professor Randolph Winslow, Dr. William Osler, Regius Professor of Medicine, Oxford University, England, says: "I am so glad to see the old school is booming. After all, you fellows have done splendidly for it, and it is a great credit to your brains and pockets."

MARRIAGES

Dr. Kivy I. Pearlstine, class of 1906, of Charleston, S. C., was married on Monday, June 5, 1911, to Miss Rita Henriette Pinkussohn, daughter of Mr. and Mrs. I. S. Pinkussohn, also of Charleston, S. C. The couple will be at home after June 20 at 126 Calhoun street, Charleston.

Miss Anne E. Chapman, University Training School for Nurses, class of 1906, was married on May 24, 1911, at Mount Calvary Protestant Episcopal Church, Baltimore, to Mr. Joseph E. Wright of Easton. The couple will reside in Easton.

DEATHS

Dr. Richard Sappington, class of 1851, died at his home in Waverly, Baltimore, Md., May 14, 1911, aged 84 years. Dr. Sappington was born in Darlington, Harford county, Maryland, March 14, 1827, the son of the late Dr. John Sappington and Lavinia Bagley Sappington. His grandfather, Dr. Richard Sappington, for whom he was named, was a surgeon in the Continental Army in the Revolution. Of himself he says in a sketch, which is a treasured relic in his family:

"Until 1846 I attended school in Harford county at Darlington Academy. There I read Cæsar, Virgil and Cicero and acquired some knowledge of Greek. These languages were of great assistance to me later in the study of medicine. In 1846 I decided to leave Harford county for Baltimore city. I wrote to a friend in the city, Thomas Piggott, who had formerly lived opposite our home in Darlington, and asked him to find me a situation, 'even if it should be in a drug store.' In 1846 I came to Baltimore and at once began to learn the apothecary business.

"In 1848, on St. Valentine's day, I bought the stock and fixtures of a drug store on Pennsylvania avenue and moved the outfit to Gay and Asquith streets. While conducting the business I attended the Maryland University, where I was graduated in March, 1851.

"Soon after I was graduated in medicine I applied for admission to the Medical and Chirurgical Society of Maryland. This society would not accept me because I was a druggist. I understood that the Maryland College of Pharmacy would not admit me because I was a physician. Later the College of Pharmacy changed in that respect, and I joined it."

For 35 years Dr. Sappington kept a drug store on Gay street, between High and Front streets, and 14 years ago moved the business to the southwest corner of Gay and Lexington streets. He had lived 42 years in the house in which he died.

Dr. Sappington was an honorary member of Concordia Lodge of Masons and a member of Monumental Lodge of Odd Fellows. For 25 years he had been a vestryman of St. John's Church.

A widow, Mrs. Aralanta Robbins Smith Sappington; three daughters, Mrs. James H. Giese, Mrs. William G. Hall and Miss Gertrude E. Sappington; two sons, Dr. Purnell F. Sappington of Belair and Mr. Reginald P. Sappington; ten grandchildren and four great-grandchildren survive him.

Dr. Joseph T. Pindell, class of 1865, a medical cadet in 1864, and then for two years surgeon in the Army, at one time a member of the Council and Mayor of Wellsville, Kans., died at his home in that city May 22, 1911, from nephritis, aged 81.

While temporarily deranged from overstudy Dr. George W. Hafele, class of 1908, committed suicide of shooting himself with a .32 calibre revolver May 3, 1911, at the residence of his sister, Mrs. C. Catherine Burke, 1833 Pennsylvania avenue, Baltimore. Dr. Hafele was a native of Philadelphia, and came to Baltimore about nine years ago, entering the College of Physicians and Surgeons, and then finishing his course at the University of Maryland. After a short period

of practicing in Baltimore he accepted a position as resident physician in the Adarian Hospital, Punxsutawney, Pa., resigning six months ago to engage in the practice of his profession.

Dr. Reuben A. Wall, class of 1904, died at his home in Catonsville, Md., May 4, 1911, aged 34 years. Dr. Wall was the son of Alexander M. and Ida M. Wall. Dr. Wall was generally beloved, and his classmates and associates will sorely miss his presence. He is survived by his wife.

Dr. Norman F. Hill, class of 1881, of The Walbert, Baltimore, died at the Mercy Hospital, Baltimore, May 12, 1911, after an operation for gall-stones.

Following the operation his condition improved, and at the end of two weeks he was able to leave his bed and be wheeled about the halls. Later, however, he suffered a relapse, and sank rapidly.

Dr. Hill was born at Thorpland, Prince George county, Maryland, in 1847. He was the youngest son of the late Charles and Anne Elizabeth Snowden Hill. After graduating from Georgetown University in 1866 he came to this city and studied medicine at the University of Maryland Medical School, receiving the degree of doctor of medicine in 1881.

Dr. Hill was a member of one of the most prominent families of the State. He traced his descent from the Hills of Somersetshire, England, one of whom came to the province of Maryland in 1662 in company with Charles Calvert, the third Lord Baltimore.

He is survived by his widow, Mrs. Carolyn Hill; one daughter, Mrs. Lylden Brice of Chestertown, Kent county, Maryland; six sons—Messrs. Norman F. Hill, Jr., and Carroll E. Hill of St. Louis; Ernest M. Hill of Buffalo; Richard S. Hill of Atlanta, Ga., and Joseph K. and Nevitt S. Hill of this city—and two brothers, Mr. Eugene Hill of Kansas City, Mo., and Major N. S. Hill of this city.

Dr. Cameron Piggott, class of 1882, died at his home in Sewanee, Tenn., April 30, 1911, aged 55 years. Dr. Piggott was Professor of Chemistry at the University of the South.

Dr. Frederick B. Baker, class of 1888, died at his home in East Norwalk, Tenn., April 14, 1911, aged 79 years, of cerebral hemorrhage.

Dr. Robert Atkinson, class of 1854, died at his home in Baltimore May 22, 1911, aged 79 years.

LABORATORY REPORT OF THE UNIVERSITY HOSPITAL.

Month of May.

Blood Examinations.

Leucocyte counts	169	
Erythrocyte counts	13	
Differential leucocyte counts	8	
Hemoglobin determinations	84	
Smears for malarial parasites	5	
Blood cultures	8	
Wasserman tests	18	
Widal tests	26	
		331

Urine Examinations.

Routine urinalysis (chemical and microscopic)	380	
Total estimation for urea	5	
Total estimation for albumen	4	
Total estimation for sugar	2	
		391

Miscellaneous.

Gastric contents (chemical and microscopic)	13	
Feces (microscopic, etc.)	13	
Sputum examination	18	
Bacteriological cultures and smears (from operative cases)	7	
Vaginal and ureteral smears	10	
Examination of spinal fluid	2	
Examination of pleural exudate	2	
Sections of tissue for microscopical examination	15	
Autopsies	2	
		82
Total		804

Dr. J. L. Hirsh,
Dr. H. J. Maldeis,
Dr. R. Diller,
Dr. R. C. Dodson.

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REPORT OF TWO CASES OF FATAL GASTRIC HEMORRHAGE.*

By A. ALDRIDGE MATTHEWS, M.D.,
Class of 1900.

Before reporting these cases I would like to run over briefly some of the causes of hemorrhages from the stomach due other than to cancer and ulcer, and I cannot do better than to quote from Dr. I. Boas.

Besides ulcer and carcinoma, portal vein stasis, gastric varicosities, trauma, scurvy, hemophilia, leukemia, Hodgkin's disease, acute yellow atrophy of the liver, ruptures of blood vessels, acute infectious fevers, such as typhoid; yellow fever, cholera, plague, malaria (Hemmeter), acute and chronic gastritis (ulcerosa) and pyloric stenosis, miliary aneurisms, corrosion through caustic poisons, syphilitic and arteriosclerotic conditions, hysteria, cholelithiasis, etc. The hemorrhages of gastric carcinoma are usually easily differentiated from those of ulcer. The former are, as a rule, small in quantity; they do not bring about bloody stools, or at least very rarely; the blood is decomposed and of a coffee or chocolate brown color. Cases of carcinomatous ulcers and carcinoma of the cardia, in which severe hemorrhages occurring toward the end may terminate fatally, are exceptions. In rare cases of hysteria and crises gastriques hematemesis has been reported. These instances are very rare, and the picture is essentially different. In such cases, however, organic or functional nervous diseases may be coincident with ulcer, as Debove rightly emphasizes.

Hemorrhages resulting from stasis in cases of liver affections, especially cirrhosis, may easily be mistaken for hemorrhages from gastric or duodenal ulcers. Leichtenstern pointed out that there is a form of cirrhosis of the liver which may give almost the precise picture of the course of an ulcer. Repeated, usually very copious, gastric hemorrhages, which return in intervals of weeks and months, take place. The patients are very anemic, not at all jaundiced, ascites and enlargement of the spleen are absent, probably on account of considerable hemorrhages, through which the portal circulation is relieved. Leichtenstern found a latent cirrhosis of the liver in several cases of this kind which terminated fatally within a few days from repeated gastric hemorrhages.

We should always, therefore, think of the possibility of a developing cirrhosis of the liver in all cases of sudden gastric hemorrhages of persons who had been healthy up to this time, and the more so if symptoms of a gastric ulcer have not preceded or followed a hematemesis (Oppolzer). Gastric hemorrhage or melena occurs in cases of cholelithiasis with or without icterus, and may suggest gastric ulcer, particularly as other subjective or objective symptoms may be entirely absent at this stage, or may be masked.

Differential diagnosis may be often difficult in cases where hemorrhages occur suddenly, and previous history does not give any hints. Decrease of liver dullness and enlargement of spleen may be decisive, though their absence does not exclude cirrhosis of the liver, as just mentioned. Where previous history is known, we have on the one side to pay attention to the presence of epigastric painfulness, which is either missing entirely or, if present, is only slight, and on the other side, syphilis or abuse of alcohol.

Besides the above-named sources, there are certain parenchymatous hemorrhages, for which Harttung suggested the name of "plica-hemorrhage," as they usually originate in the folds of the gastric and intestinal mucosa. In these cases

*Read at Moscow, Idaho, April 10, 1911. "North Idaho District Medical Society."

the gastric mucosa may be perfectly intact, with the exception of small erosions, visible sometimes only by the magnifying glass. Dieulafoy recently described these occasionally fatal ecchymoses, which affect only the most superficial strata of the gastric mucosa, as "exulceratio simplex," and sees in them the first stage of the true Cruveilhier's ulcer.

Case No. I.—White; male; single; age 27; a carpenter by trade. Physical examination negative, except liver dullness decreased, spleen palpable. His past and family histories were negative, with the exception of having had several hemorrhages from the stomach within the last two or three years. None of these hemorrhages were very severe, except the present one. He gave no history of being a bleeder, nor did he give any history of any gastric disturbance whatsoever, except a little dyspepsia, and he had drunk considerably at intervals. I saw him a short while after a hemorrhage, and suggested to him an operation, thinking at this time that he had a gastric ulcer, although the symptoms pointing to an ulcer were rather negative. I had never seen a hemorrhage from the stomach other than from ulcer or cancer at this time, and my diagnosis was made more from the hemorrhage than from any other symptom. He submitted to an operation, and, after thoroughly examining his stomach, I elicited no induration or thickening anywhere that would suggest an ulcer. Not being satisfied, I examined the stomach as carefully as I possibly could the second time, thinking I might have overlooked something, but was not any more successful than before. I did a gastro-jejunostomy, for I still thought there must surely be an ulcer which I could not find. This patient made an uneventful recovery, so far as the operation went, up until the eighteenth day, at which time he was up and about, but on that day he had a violent hemorrhage from his stomach, vomiting blood; also passing blood in his stools, and died within 12 hours from the time hemorrhage started from shock.

On this case I had a post-mortem, and found a hemorrhagic condition of the mucous membrane of the whole cardiac end of the stomach, extending well up into the esophagus. There was no evidence whatsoever of ulcer anywhere to be found. I appreciate now that my gastro-jejunostomy was of no avail, and could not possibly have done him any good. The other pathological condition that I found was a large spleen and a much contracted liver, the cut surface showing a grayish-white appearance surrounding greenish-yellow island-like areas.

The liver substance being much firmer than normal and cut with considerable resistance, I should have made my diagnosis of cirrhosis of the liver when I operated, but this was five years ago, and time, with experience, is our best teacher. My mind was centered on the trouble being in the stomach, and I did not consider these other conditions as I should and would do today.

Osler claims that the most extreme grade of atrophic cirrhosis may exist without symptoms; so long as the compensatory circulation is maintained the patient may suffer little or no inconvenience. The remarkable efficiency of this collateral circulation is well seen in those rare instances of permanent obliteration of the portal vein.

Case No. II.—L. E. A.; age 33; white; male; married; occupation laborer; family history negative; physical history negative; rarely took a drink; no history or evidence of syphilis; physical examination negative. Past history negative, with the exception that about 14 months ago he was referred to me with a great deal of pain radiating over the upper part of his right abdomen and vomiting. This pain had persisted three or four days before I saw him. He gave no gastric symptoms, and claimed never to have suffered with indigestion or any gastric disturbance, although he gave history of having had several gastric hemorrhages, the first one occurring about seven years ago. He thought he vomited possibly three or four ounces of blood, and from that time up to the present he has had four hemorrhages of considerable size, each time vomiting anywhere from an ounce to four ounces of blood, and having tarry-black stools. About two years ago he had quite a severe hemorrhage, which incapacitated him from work for a few days, but at no time did he have the least distress or discomfort before or after eating, or during his attacks or hemorrhages. He has had no hemorrhages for the past year. Upon palpating his abdomen (14 months ago) I could detect a large hard mass extending down from under the costal border to the right, which gave him considerable pain upon pressure, and moved up and down in deep breathing, which I diagnosed as a distended gall-bladder.

I opened the abdomen, making the usual in-

cision, and found a very much distended gall-bladder, having a whitish appearance and quite tense, which I drained, but found no stones—only viscid mucus. Neither could I detect any obstruction or trouble in his cystic duct, although there was no bile present in the gall-bladder at that time. I inserted a tube, which I left in for about eight days. There was very little drainage, and that which did come away was only slightly stained with bile. I was very much concerned as to whether there was some obstruction in the cystic duct which I had overlooked, but upon removing the drainage tube the tract healed at once, and he had no further trouble and no return of his old condition. I saw him several times between the operation and his present illness; at no time did he have any further trouble or discomfort with his gall-bladder, and did laboring work from that time until present illness. I examined the stomach for ulcers, especially on account of his history of previous gastric hemorrhages, but apparently the stomach was normal at this time.

He was again referred to me on December 19, 1910, after having had several hemorrhages, and at the time I saw him he was practically bloodless, facial expression very much pinched, and the ordinary symptoms that go along with severe hemorrhage. I had him transferred to the hospital, and transfused him as soon as I could get a suitable subject who would volunteer to give up his blood. At this time I opened a vein in his arm and used the radial artery of the donor, who was a young laborer (white). Would have preferred some blood relation for this, but he had none in this section of the country. The transfusion was a great success, the patient's condition improved immediately and his general appearance and condition was wonderfully changed for the better and his outlook bright, but the following night he had another hemorrhage, in which he vomited at least six or eight ounces of bright red blood, and his condition was the same as it was the day before. On this occasion I transfused him again, this time getting a brother-workman, using his radial artery and the vein in the opposite arm of the recipient, and the improvement was equally as much as it was the day before, but the following night he had another hemorrhage, and almost died from shock before relief could be had. And then again, the third donor, a large plethoric man, lawyer by profession, was used, and this time I used the radial of the donor and a superficial vein of the leg of the recipient. At this time his improvement was greater than at either of the preceding ones. The pinched expression left his face entirely, his ears became pink and, as I said before, I considered his condition better than it had been following the other transfusions. About 15 hours later he had another hemorrhage, and died as a consequence.

I might say, also, that I fed him gelatine the whole time that he was under my observation. Two of the donors were paid, or, in other words, hired to give up their blood.

Of course, the question arose as to where he was bleeding from, whether from an ulcer or erosion, or just a hemorrhagic condition of the stomach due to cirrhosis of the liver. The condition that was most forward in my mind was that of ulcer, although it made me feel doubtful, because at no time had he ever complained of distress or indigestion, and I could not elicit any such history from him, although I inquired into this especially. That made me a little skeptical, but upon a post-mortem I found nothing except a hemorrhagic condition of the mucous membrane at the cardiac end of the stomach. The rest of the mucous membrane and his stomach appeared to be normal. There was one place at least two inches in diameter that showed evidences of having bled near the esophegal opening. The gall-bladder was functionating, although very much thickened, and there was no evidence that it had given him any further trouble. There was no stones in any of his ducts. I had sections made of his liver, and found little or no cirrhotic condition existing, but there was a passive congestion. The size of the liver seemed about normal, but I had no means of weighing it at that time.

In the April issue of THE BULLETIN we stated that we were unable to locate several members of the class of 1885. We have since learned that Dr. J. B. Carr died November 20, 1907; Dr. William P. Kennedy died November 9, 1902, and Dr. W. T. Spruill died July 28, 1895. We would be very glad if our readers would assist us in locating Drs. J. M. Emmitt, B. B. Halsey, E. K. Hardin, C. H. Janney, H. C. Jamison, D. T. E. Casteel, P. B. Carter, S. B. Dew, A. F. Keen, E. T. May and C. E. Rogers, all of the class of 1885.

Dr. Harry W. Stoner, class of 1907, is recovering from an infected hand.

SKIN-GRAFTING—WITH A REPORT OF TWO VERY SUCCESSFUL CASES RECENTLY PERFORMED IN THE UNIVERSITY HOSPITAL BY DR. RANDOLPH WINSLOW, PROFESSOR OF SURGERY, UNIVERSITY OF MARYLAND.

By Burt J. Asper, '11,
Senior Medical Student.

Skin-grafting is a part of that special branch of operative surgery to which the term plastic or reparative has been applied, and which has for its object the reconstruction of the contour of the body for cosmetic reasons, the readjustment of anomalous relations of parts for utilitarian purposes, as well as the substitution of one organ or tissue for another to give physiological efficiency.

The inception of this branch of surgery probably dates back many centuries; certain it is that in India the surgical restoration of the external nose, which is often cut off in that country for supposed marital infidelity, has been practiced for many years before the first published records of methods and results were put into the hands of the surgical profession.

This was first done in the latter part of the sixteenth century, when Togliacozzi of Bologna published an illustrated volume in which he dicussed the possibilities of plastic surgery with reference especially to nasal reconstructions, but for nearly two centuries this important surgical contribution made but little impression upon the surgical world. It was in the middle of the eighteenth century that the revival of plastic surgery was begun—when Rosenstein and Dubois discussed the possibility of replacing lost structures by reparative operations and proved that reconstructive surgery was possible by securing historic evidence of noses and lips having been made from the tissues of forehead, thigh and buttock by Indian and Italian surgeons of previous centuries. Following this the experimental work of John Hunter on the grafting of tissues was done.

From this time on the interest in reparative surgery became very great, but the greatest strides were not taken until after the investigations of Lister, which made the aseptic healing of wounds possible. From this time on the field of reparative surgery widened rapidly, and there were established as legitimate operative procedures successively, epidermis grafting, tendon transplantation, nerve grafting, arteriorrhaphy and arterial transplantation, oseoplastic resection and reconstruction, thyroid grafting, etc., until at present the transplantation of internal organs, blocks of varied tissues and even of whole limbs seems a possibility of human surgery.

The specific purpose of skin-grafting is to supply a cutaneous covering to any part of the external surface of the body, the superficial structure of which has been lost from any cause whatever; wounds, burns or ulceration, thereby either accelerating a healing which would have occurred very much more slowly, or rendering possible the production of continuity in tissue which nature unaided would never have effected, and at the same time avoiding the deformities and impairment of function which so constantly result when such raw surfaces are permitted to heal by the natural process of cicatrization.

The physiological basis for the operation of skin-grafting is the process of growth and repair of living tissues, supplemented by the ability of groups of animal cells to retain their vitality for a short time, even when separated from all direct connection with the heart and central nervous system.

Successful operations demand aseptic wounds, sound tissues and good general health of the patient. As syphilis and lupus are frequently the cause of the lesions demanding skin-grafting, it is absolutely essential in the first disease that some months shall have elapsed since any manifestations of syphilis were detectable, and that the patient shall have been treated for a prolonged period with antisyphilitic remedies, while in a patient who has suffered from lupus, it is imperative that all the diseased tissue should have for some time been destroyed. It is absolutely essential to success that complete asepsis be secured and maintained, because all antiseptics endanger the vitality of the graft, and when in any part of the operation antiseptics are required to secure asepsis, they should be thoroughly removed by the prolonged use of sterile normal salt solution. The deprivation of the protoplasm of the cells of their living power by bacterial and chemical irritants constitute the chief cause of failure in this operative procedure.

Skin-grafting is performed in three ways—the Reverdin method, the Thiersch method and the

Wolfe or Krause method. In the first, very small particles of the epidermis with the underlying upper layer of the corium are transplanted. In the second, long strips of the same material are used, while in the third, pieces of the entire thickness of the skin several square inches in size are transplanted upon the raw bed. The first two might with propriety be called epidermatoplasty; the last dermatoplasty. The grafts are usually obtained from some other portion of the patient's own body, the skin of the front and inner side of the thigh and arm being preferable, since it is elastic and not apt to be excessively hairy, while the resulting cicatrization is on a part of the body covered by clothing; or, the graft may be obtained from the body of another individual. It is best that the donor be young, and all possibility of specific trouble must be excluded, as syphilis may prevent the graft from taking. The skin of any of the lower animals may be employed, especially that covering the abdomen of the frog. Since it is not definitely known whether graft from the skin of a negro transferred to a white patient will remain pigmented, it is best always to graft blacks from blacks and whites from whites.

Thiersch's Method.—Thiersch states that healing of a granulating surface results, first, from a conversion of the soft vascular granulation papillæ by contraction of the young connective tissue cells into "dry cicatricial papillæ" actually approximating the surrounding tissues, thus diminishing the area to be covered by epidermis, and secondly, by the covering of these papillæ by epidermic cells. Contraction having gone on as far as the laxity of the tissues will admit, and the capacity for developing new epidermic cells by the margins of the wound being limited, the granulations of the unlimited central portion remain stationary, *i. e.*, vascular and soft; few, if any, of these component cells having undergone development into connective tissue, the maximum of contraction has not yet been attained, but will be promptly reached if they are covered by epidermis. Furthermore, microscopically, two layers of granulation tissue are discoverable, the more superficial possessing vertically disposed capillaries, the deeper containing a horizontal network of vessels from which the former spring, coursing through a structure more or less dense, according to the age. A free removal of this upper soft layer of granulations, yet capable of full contraction, must be effected to prevent cicatricial contraction and the risk of separation of the epidermis, this danger being avoided by laying the graft directly upon the layer of granulations with horizontally disposed capillaries, to which layer the transplanted portions will become firmly adherent, and will remain so, undisturbed by cicatricial contraction.

Method of Operating.—Complete asepsis having been secured as before indicated, and all antiseptics washed away with salt solution, the soft granulations are scraped away with a sharp spoon, including a small portion of the newly-healed margins if they do not appear healthy, and the bleeding surface irrigated. All bleeding is stopped by compression with an antiseptic pad of gauze. The operator then reverts to that portion of the body from which the grafts are to be obtained, usually that of the thigh or arm, the part having been previously shaved, sterilized and bathed with sterile salt solution. The skin is put upon the stretch by one hand, while with the other a wide, sharp razor is applied flatwise, best previously wet with sterile salt solution, and the upper layer of the skin removed by a to-and-fro movement of the knife, the skin also being wet with the salt solution. Each graft should be as broad and as long as possible, should include only the most superficial portion of the true skin with the corresponding epidermis, and should be immediately laid upon the prepared surface, upon which it is floated from the knife by salt solution. A probe may be used to facilitate this movement, drawing the edge of the graft on to the edge of the wound surface while slipping the blade away; subsequent correction of position may also be effected by the probe. Each graft must be gently pressed into place, and must be in contact with its neighbor, or, better, slightly overlapping its fellow and the margins of the wound; otherwise, separation of the grafts is apt to occur.

Having placed as many grafts as desired, the grafted area is covered by rubber tissue, previously perforated in many places, so as to allow the free escape of any fluid, serous or purulent, which may accumulate; over this a dry gauze dressing so firmly applied as to press the graft against the raw surface. It is left undisturbed, usually, for five or six days. Some operators prefer an aseptic moist dressing, kept continually wet. It is usually advisable to anesthetize the patient from whom the grafts are taken, although local infiltration anesthesia has been employed.

The appearance of blood beneath the graft as

indicated by a bluish color, while endangering their vitality, does not necessarily cause their loss. A pink tint at the end of several days usually indicates success, while if the grafts be at this time of a dead white color, they will probably exfoliate, although only the outer layers may disappear, while the deeper active ones remain; sometimes the grafts are perforated by the granulations, and disappear for a time, to reappear as epidermic islets later on. The surfaces from which the grafts were obtained are dressed with dry sterile gauze, or first dusted with iodoform and then sterile dressings applied.

The Thiersch method is very valuable; by its use very large ulcers and wounds can be made to heal quickly. It is especially valuable in causing rapid cicatrization of large ulcers following burns, the grafts in such cases being applied as soon as the sloughs have separated and the surface can be made sterile, since delay allows cicatricial contraction to become increasingly great. The immediate union between grafts and vivified granulation surface tends to obviate much of the disfigurement likely to occur from vicious cicatricial contraction. This method does not make a deep wound where the grafts are cut, so that quite large surfaces will heal rapidly. Keetly states that a valuable use of this method is to line deep aseptic bone cavities, which frequently begin to fill up by tissue developing under the grafts. He also believes that epitheliomatous and tuberculous ulcerations which have been excised show less tendency than usual to recurrence if Thiersch's grafts are employed to fill up the gap in the soft tissues.

Reverdin Method.—Having rendered the ulcer and the neighboring skin and the part from which the grafts are to be taken sterile, the point of an ordinary aseptic sewing needle should be thrust under the epidermis, the skin elevated and the grafts shaved off by a sharp scalpel, or cut with a pair of small curved scissors. To be sure of obtaining the deeper active epithelial layer, a small portion of the derm should always be removed. The grafts must then be gently deposited, with the cut downward, upon the granulations by means of the needle, avoiding pressure such as will induce bleeding. Perforated rubber tissue is then placed over the graft, sterile dressing applied and left undisturbed for four or five days. In many instances these small grafts shed their cuticle and become invisible, the operation apparently having failed from a loss of the entire graft; but at the next dressing commencing growths of epidermis will often be shown by bluish-white spots not only where the grafts were supposed to have taken, but also where they were thought to have been shed. As the grafts extend eccentrically, each capable only of producing an area of about one-half inch of cicatrix, they should be placed about half an inch from each other and the margin of the wound. The islands grow in extent, and apparently stimulate the edges of the wound or ulcer to similar activity, until after a time the islands of cutification coalesce and join with the margin, and the former raw surface becomes completely covered with skin. As is also true in the case of the Thiersch method, if one grafting will not suffice, the operation should be repeated.

Unfortunately, but little diminution of the cicatricial contraction is effected by the Reverdin method, and, while healing is more rapidly secured, too often an almost equally rapid breaking down occurs of the new-formed cicatrix, either from no recognizable cause or from causes which would be inadequate to produce such a result in a scar formed by the ordinary process of healing.

Wolfe or Krause grafts consist of the entire thickness of the skin, and must be free from subcutaneous fatty tissue. The circumference of the free flap to be cut is marked by an incision through the skin. An end is then seized with forceps and raised, so that the operator is able to dissect it free from the superficial fascia. The knife used should be sharpened; its edge should be turned toward the skin, in order to avoid raising some of the subcutaneous fatty tissue with the skin. The raw surface should not be touched with the finger, and the operation should be dry. The graft may be obtained by dissecting up skin and subcutaneous fat from the deep fascia and then clipping all the fat away from the under surface with scissors. This method leaves a wound easily closed after undercutting its margins. The graft is carefully laid in the bed that has been aseptically prepared, and is pressed into place, so as to drive out any air beneath it. Sutures may or may not be used. Dry dressings are to be firmly applied, and are not removed for about four days. Then there may be blebs on the surface, and it may look as if necrosis of the flap was about to occur. The blebs should be punctured and drained, and dry antiseptic dressings applied. They usually live

if proper technique has been carried out, even if they are several square inches in area. Motion of the part to which the grafts are applied should be prevented by means of splints whenever necessary.

CASE I. SKIN-GRAFTING OF HAND, BOTH PALMAR AND DORSAL ASPECTS, AS FAR AS THE WRIST JOINT, FOLLOWING CRUSHING OF THE FINGERS AND DENUDATION OF THE HAND BY CORN-HUSKING MACHINE.

Patient, E. R.; white; male; age 16. Admitted to University Hospital to the service of Prof. Winslow on the evening of January 4, 1911.

History.—On the afternoon of the above-mentioned day, while feeding a corn-husking machine, patient introduced his right hand into the machinery to free an ear of corn which had become lodged; in so doing the hand became caught, and dragged between the rollers. Patient threw machine out of gear at once, but could not free his hand until machinery was taken apart by his fellow-workers, the whole process requiring about 15 minutes. The physician who was called dressed the wound and hurried the boy to the University Hospital. Examination revealed that all four fingers and thumb of right hand were badly lacerated, and the skin of the remainder of the hand was entirely stripped off as far back as the wrist, very much after the fashion of the removal of a kid glove.

Treatment.—Patient was prepared for operation at once upon admission; was given an anesthetic and the hand thoroughly scrubbed up and treated with antiseptics, following which the skin was replaced over the denuded surface and sutured in position, openings being made at several places through this skin for the insertion of drainage.

Temperature on admission was 99 5-10° F. The next day temperature reached 103 and pulse 120, in the meantime patient suffering very severe pain. He was treated by ice to the head and anodynes, and 1500 c. c. of antitenanic serum was administered. The infection proved too virulent, and, despite the fact that the hand was kept immersed in a continuous hot bichloride bath, the replaced skin, and also the fingers, began to slough, the process continuing until the thumb and all the fingers were separated at the metacarpophalangeal articulation.

With careful attention the infection was overcome, and the general condition of the patient became very good, and the operation of skin-grafting was deemed advisable in order to shorten convalescence, and also to prevent the deformity and loss of function, which would have resulted from cicatricial contraction had the raw surfaces been permitted to heal by the process of granulation.

Operation.—The grafting was done in two operations, the Thiersch method being employed in each. At the time of the first operation, on February 11, the dorsal surface was covered, the skin being taken from the left thigh. On March 8 the palmar surface was grafted, the grafts this time being secured from the right thigh. At the time of this second operation there was present in the middle of the area an island of cicatricial tissue about the size of a quarter. This was permitted to remain and the grafts made to surround it.

Results.—The grafts took beautifully; there was no sign of sloughing. The stump, which at the time of grafting was large and ruddy, and had scarcely any semblance to a hand, decreased in size progressively, until at the time of discharge it had assumed practically normal proportions. Patient was discharged on April 8, the hand being completely covered by skin, with the exception of two small spots, dime-sized, one upon the radial and the other upon the ulnar side of the dorsal aspect of the hand, which were quite healthy in appearance. There was no cicatricial contraction whatever, motion at the wrist and between the carpometacarpal articulations, including that of the thumb, being perfect.

CASE II. ANNULAR ULCER OF RIGHT LEG, LARGE ULCER OF LEFT LEG.

Patient, Mrs. M. W.; white; age, 43; occupation, housewife. Admitted to University Hospital on February 9 to the service of Prof. Randolph Winslow.

History and Examination.—The duration of the ulceration on the left leg was given as four years, while that of the right leg was of six months' duration. No history of syphilis could be obtained. The left leg was encircled at a point about two inches above the internal maleolus by an infected sloughing ulceration about four inches

in width. On the right leg, also about two inches above the internal maleolus on the internal aspect of the leg, was a second ulcer, which measured about as follows: Two and one-half inches in length, two inches in breadth at base and one inch at apex. Its surface was also sloughing and infected. Both legs were greatly thickened and indurated, both above and below the ulcerated areas.

The patient was put to bed; the ulcer of the left leg was cleaned antiseptically and hot compresses applied over the ulcerated area every two hours, this treatment being continued for 24 hours. At the expiration of this time soap poultices were applied twice daily until February 12, the day of operation. The evening of the previous day the right thigh of the patient was shaved, prepared aseptically and soap poultices were applied until the time of operation. The ulcer of the right leg had been cleansed at the time of admission, and sterile dry dressings were then applied. It was not intended that both legs should be grafted during the same operation, but at the time of this operation it was decided that both legs should be grafted, which was done accordingly, grafts being applied not only to the left leg, which had been prepared according to usual routine, but also to the right leg, which has received no preparation other than the cleansing at the time of operation. The Thiersch method was employed, both ulcerated surfaces being covered with grafts obtained from the right thigh. They were then covered with perforated gutta percha, and sterile dry dressings employed.

The dressings were removed in four days. Some suppuration had taken place, the surfaces being quite moist, and the issue was at this time rather doubtful, but at the time of the succeeding dressing, five days later, it was found that the grafts on both right and left leg had taken kindly; there was no more suppuration, and the areas had a healthy pink color. After this dressing the gutta percha covering was discontinued, and the legs washed daily with sterile normal salt solution and alcohol and dressed with smooth sterile dressings.

Healing went forward uninterruptedly until, on March 20, the patient, whose general condition had become excellent, was discharged "cured," all raw surfaces being completely covered over by new skin.

A FURTHER ANTHROPOMETRIC STUDY OF ENTEROPTOSIS — REPORTED FROM THE CLINIC ON DISEASES OF DIGESTIVE ORGANS — PROF. JOHN C. HEMMETER, WITH THE HISTORY OF A CASE OF ENTEROPTOSIS, ACCOMPANIED BY AN ANTACID GASTRITIS AND MARKED ATONY.

By Albert Hynson Carroll, M.D.,
and
Walter C. Bacon (*Senior Medical Student*).

The conditions of displaced abdominal viscera had been the "Pons Asinorum" of clinicians until the brilliant French clinician Glénard began to publish his life work on these abdominal states.

Glénard published his first scholarly researches in a journal known as *Lyon Médicale* in March, 1885. ("Enteroptose et Neurasthenie.") He has

Figs. 1 and 2.—Typical enteroptic figure, poorly nourished, muscular insufficiency. Note small size of thorax as compared with pelvis, and the weak abdominal walls. Stomach two inches below the umbilicus. Transverse colon prolapsed. Nervous symptoms marked.

since then published many interesting studies on the nervous, physical and chemic abnormalities of displaced abdominal viscera.

It was he who first coined the word "enteroptosis."

In the year 1853 Virchow reported autopsy findings which led him to argue that in the majority of cases they were the result of local peritonitic processes. It is doubtful if Virchow ever

reported a case of genuine enteroptosis as Glénard conceived it, for these typical cases are congenital, and are not accompanied by any evidence of peritonitis.

Many prominent European and American observers became interested in enteroptosis after Glénard's epoch-making publication. The literature is too extensive to even cite the more important articles.*

This literature consists mostly of speculations concerning the causes of this intensely interesting pathologic state.

The best contribution was made by Stiller—"Die Asthenische Konstitutions krank heiten"—in which the first clinical logic is given that proves this condition to be not simply an abdominal displacement of the digestive organs, but a distinct constitutional anomaly that is inherited, and is almost always accompanied by an infirm nervous system and a poorly-developed musculature.

The next most instructive contribution was by Hemmeter.†

For the first time it was here clearly shown that enteroptosis could be recognized by the disproportions of their bony dimensions, and secondly, that their hearts, were as a rule, displaced also. Hemmeter regards enteroptosis as a pathologic product, a sign of a hybrid race, and makes interesting biological suggestions concerning its origin.‡

CASE 24,146, UNIVERSITY HOSPITAL DISPENSARY.

Name, J. W.; age, 22 years; race, white; sex, male; social condition, unmarried; occupation, "surveyor's helper."

Diagnosis.—Antacid gastritis, with gastroptosis and marked gastric atony.

Family History.—This shows us nothing. His parents were not blood relatives, as far as he knew. There was no history of tuberculosis, cancer, syphilis, gout, rheumatic tendencies or nervous diseases. Both patients are alive and well.

Past History.—The patient has had the usual diseases of childhood, but has not had typhoid fever, appendicitis, any veneral diseases or marked gastric disturbances in the past. He states, however, that he has had slight attacks of heartburn, and has been somewhat constipated at times during the last few years, but that for the last 10 years he has not been really sick up to the time that his present trouble began. He denies any venereal diseases.

Present Illness.—About two months ago, while working in the hot sun (*he is a surveyor's helper*), he was suddenly taken sick with severe "cramp-like" pains in the epigastric region. He did not faint or fall.

These pains were accompanied with nausea, but he did not vomit. He was very miserable for several days. Since then, although he has been very careful what he eats, the pains have been almost constant, although not so severe, regardless of the kind, the amount or the time food is ingested. He has not vomited food or blood. There has been diarrhea and constipation at various times since he was taken sick.

The epigastric pains are often accompanied with burning pains in the back. (Ulcer was thought of, but later findings—absence of free HCl., etc.—ruled this out.) He eructates frequently; at times some food particles come up, and he complains of a lump rising up into his throat after eating, of being hungry, but afraid to eat on account of the increased distress; of great thirst all the time, but he drinks but little water, as it "drags like lead" in the region of the umbilicus.

Habits.—He has led a fairly regular life; denies the use of any alcoholic beverages, but has smoked inveterately for several years "to quiet his nerves."

The head, mouth and throat show nothing of importance. His lungs are negative. The heart extends toward the middle line. (*Note Hemmeter's observations on this point.*)

There were no valvular lesions noted. The pulse was regular and of good tone.

His chest is long and narrow, with two floating tenth ribs.

The subcostal angle also attracts attention; it is only 69°.

The liver, kidneys and spleen were not palpable. The stomach, on dilating with air, reached to about two inches below the umbilicus. The transverse colon was prolapsed also.

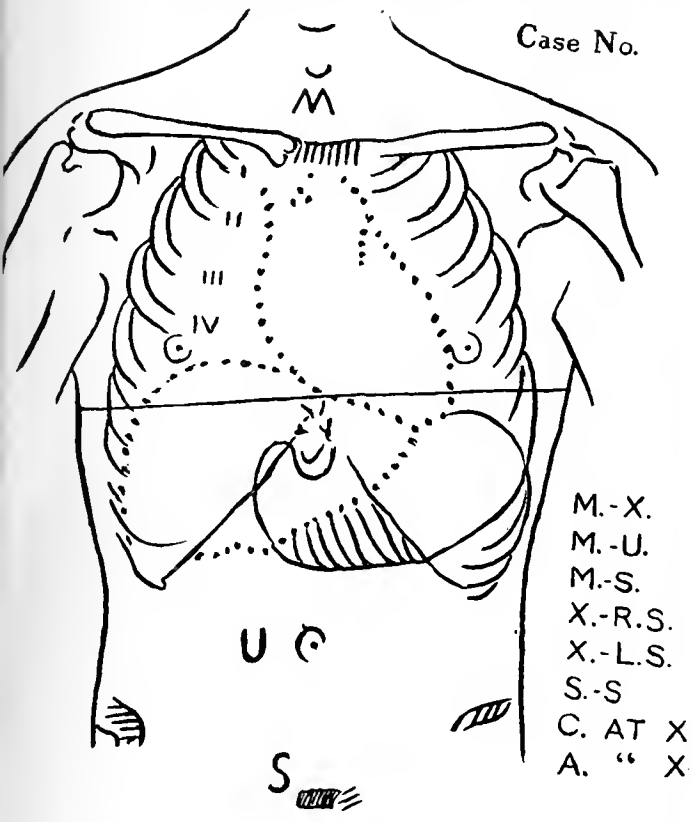
All of the reflexes are normal. There is no apparent anemia. The blood was not examined.

*See Hemmeter's textbook on "Diseases of the Stomach," and also his two-volume work on "Diseases of the Intestines."

†"Anthropometric Studies of the Osseous Proportions, with a View to Obtaining a Mathematic Expression for Enteroptosis." See R. Smith, "Enteroptosis, With Special Reference to Its Etiology and Development," *Journal A. M. A.*, Vol. lv, No. 22.

‡Sonderabduck aus: Internationale Beiträge z. Pathologie u. Therapie der Ernährungsstörungen. Bd. 2. Heft 3.

The orthopometric measurements, secondary to Hemmeter's original method, are as follows:



Height.....Weight.....Age.....
X Angle.....Pr. Weight.....

Patient's measurements are the following:
Manubrium to xyphoid, 8 inches.
Manubrium to umbilicus, 15¼ inches.
Manubrium to symphisis, 22 inches.
Xyphoid to right anterior spine, 11½ inches.
Xyphoid to left anterior spine, 11½ inches.
Spine to spine, 10 inches.
Circumference at xyphoid, 29 inches.
Angle (sub-costal), 62°.

(Some other observers, in attempting to arrive at similar results, have taken measurements which embraced the fatty portions of the body, i. e., the circumference at the level of the pelvic spines, at the umbilicus, etc. Hemmeter depends on "fixed points of the bony framework" to measure from, in much the same way as the obstetrician does when he is measuring the female pelvis. A large number of athletes at the Baltimore Athletic Club and elsewhere, including Gus Schoenline (Americus), the wrestler, and Roy Nelson, the champion swimmer, lead one to believe that Hemmeter's method is the only correct one. I am of the opinion, however, that the patient's height plays but a small part. A short man often has a sub-costal angle equal to that of a six-footer. In two well-developed men the angle, the distance from "spine to spine" and the circumference at the xyphoid are often the same, regardless of their height. Dr. Hemmeter finds that the height of the patient is necessary to secure a correct index. The small angle, the presence of movable or detached tenth ribs and the general shape of the thoracic cavity, particularly when the distance between the two anterior sup. spines is great, should call immediate attention to a probable ptosis of the abdominal viscera).

The urine was less than normal in amount (probably due to the dilation of the stomach), and was negative to albumin and sugar. Sp. gr. 1020.

Test Meal.—After withdrawing the usual double test meal, free HCl. was found absent. Cabbage and beans, eaten 48 hours previously, as well as evidences of both test meals, were observed. The odor was foul. There was not a great amount of mucus, and no occult blood. Lactic acid tests negative. The "bromine water" test failed to give the "tryptophon reaction," which might have indicated malignancy. Bile was absent.

Feces.—Negative to intestinal parasites or ova. Starch granules, bile-stained cellular particles and hairs present. Small amount of fat.

Sputum.—Negative to T. B.

Treatment.—

1. Dietary.
2. Medicinal.
3. Daily lavage before breakfast.
4. Electrical (not instituted).
5. Surgical (not advisable).

1. Dietary Treatment: The patient was put on a "bland diet"; he was told to avoid all fatty or fried foods, and that his food should be taken four or five times a day, and that thorough mastication was most important. Boiled rice, poached eggs, boiled fish, spinach, creamed mashed potatoes, milk toast, thin soup, citrous fruits, etc., were recommended.

2. Medical Treatment: Strychnine sulph. gr. 1/40 t. i. d. before and HCl. dilute gtts. 30 in water after meals were given. The bowels were ordered kept open with cascara sagrada in case of constipation.

3. The patient was given a daily lavage with a warm solution of Na. Cl. and sodium bicarb. oz. 1 to a quart of water before breakfast for 10 days, when a marked improvement was noted. Free HCl. 10. Motility was apparently also improved.

The lavage was continued for five weeks.

4. Electrical Treatment: This could not be instituted, although a Faradic current administered with an intragastric electrode was indicated to diminish the degree of dilation and as a stimulant to secretion and motility.

5. Surgical interference was thought of, but not indicated. A support of abdominal bandage would not have helped in this case.

Patient's Present Condition.—Later, after he had been under about two months' treatment, he returned to the dispensary for discharge. There was a gain in weight. The epigastric pains had entirely disappeared. A final test meal showed free HCl. 10 and no evidence of the first (8.30 A. M.) test breakfast.

This case illustrates what can be done with patience and an obedient patient. It is much to be regretted that some means (compulsory measures, if you wish) cannot be devised and put into execution by which a dispensary patient will be required to report at stated periods, and finally return for a "discharge."

A letter from the patient's pastor, or from some other reliable source, might be used as an excuse, except in emergency cases, but otherwise no way presents itself to me just now except to require a deposit, say, with the "dispensary physician," this to be refunded at the proper time. It is most discouraging to have a patient return a month or so after receiving temporary relief after three or four treatments and to have to start all over again. Suggestions would be appreciated.

"Evergreen," Hampden, Baltimore.

In our list of the class of 1897, published in the June BULLETIN, we were unable to locate Dr. W. H. Lippett. We are indebted to Dr. A. C. Everett, same class, of Rockingham, N. C., for the information that Dr. Lippett died at Pittsborough, N. C., about 1900 or 1901.

Dr. Lay Gordon Burroughs, class of 1906, of 319 South Aurora street, Collinsville, Ill., was a recent visitor to the University Hospital.

A CASE OF GASTRIC ULCER WITH GASTRO-ENTEROSTOMY PERFORMED.

Presented by

ALBERT H. CARROLL, M.D., and VERNON L. OLER and RALPH L. TAYLOR, *Class of* 1911, *before Dr. John C. Hemmeter's Clinic, University of Maryland. Operation by* J. HOLMES SMITH, M.D.

Nothing unusual presents itself in this case, except, perhaps, the prompt relief afforded by a gastro-enterostomy and the patient's rapid convalescence, the operation having been decided upon after a brief trial of medicinal treatment, under which the patient's condition gradually grew worse. His pains became continuous.

The patient first came under Dr. A. H. Carroll's treatment in the dispensary. Owing to his inability to carry out the prescribed treatment at his home, he showed no improvement, and he was then advised to come into the hospital. He did so.

PATIENT'S HISTORY.

Name, C. H.; American; white; male; age 42 years; single; occupation "packer." Dispensary No. 1728.

Complaint.—"Pains in the stomach, vomiting and loss of appetite."

Family History.—Father dead; cause unknown. Mother dead (tuberculosis, 16 years ago; he lived with her). He denies any history of malignancy, nervous, mental, kidney or cardiac diseases in his family.

Past History.—He says that he had measles when a child, but that he has never had scarlet fever, typhoid fever, pneumonia, malaria or any veneral disease. There is no history of trauma.

Present Illness.—On November 25, 1910, while at work the patient experienced severe cramp-like pains in his left epigastric region, which radiated downward below the umbilicus. He was compelled to stop work and go home. After a while these pains subsided, and he ate a little supper. The meal was followed by severe pains, which lasted during the entire night.

On the following day the pains subsided, and his condition improved. Two days later he returned to work, but after two weeks, during which time he often experienced these cramp-like pains, suffering greatly, vomiting black vomitus, but no red blood, he then came to the dispensary for

treatment. The patient was ordered to eat a test meal and return the next day at 12 o'clock. The contents, after being secured and examined, showed free HCl. 40, total acidity 65; no blood; some mucus.

Pulmonary and cardiac examinations show nothing pathological.

Nervous System.—Negative as to diseased conditions, but the patient is somewhat nervous, although he is apparently of a cheerful disposition. He complained of his inability to sleep, owing to the excruciating pains at night. This was the main reason for sending him early to operation.

Genito-urinary Tract.—Negative; no scars.

Habits.—It has been impossible to discover any vicious habits. He does not drink whiskey and but a small amount of beer. He smokes very moderately, and denies using drugs of any description.

Treatment.—The patient was told to go home and to go to bed; to eat nothing, and to drink only small quantities of milk at frequent intervals. He was given bismuth and alkalies. He returned two days later complaining that the pains were almost constant, and that he could not retain his medicine, and that even water made him vomit. He says that he had not slept for two nights. His pulse at this time was rapid, his skin cold and damp and his conjunctiva pale.

On December 24 Dr. J. Holmes Smith, Sr., examined him, and told him that to enter the hospital would be advisable. He did so the next day (December 25). He was closely observed and given medical treatment, under which his pain continued, but his vomiting ceased. He was a sick man.

LABORATORY FINDINGS (AFTER ENTRANCE).

Stomach Contents.—Free HCl., 50; combined acidity, 70; much mucus present, but visible or occult blood was absent.

Urine.—Amount, 1800 c. c.; amber color; reaction acid; Sp.Gr., 1020; albumin negative; sugar negative; an occasional granular cast.

Blood.—R. B. C. 4,500,000
W. B. C. 7,000
Hbg. 80

Feces.—Negative to occult blood.

Sputum.—Negative to T. B.

A gastro-enterostomy was done January 5 by Prof. J. Holmes Smith at this hospital.

OPERATION.

The abdomen was opened by an incision four inches long and about one inch to the left of the median line, above the umbilicus. The stomach and intestines were exposed. The bowel was caught in an intestinal clamp just beyond the duodenal jejunal flexure. An incision was made through the meso-colon, and the posterior wall of the stomach was made to project through it. The stomach was then caught in a clamp, which was placed close to the lower border. The clamped stomach and intestines were placed side by side, the intestines having been turned so as to make the peristalic movement of the stomach and intestine in the same direction. The serous surfaces were united by continued sutures for about 2½ inches, and the two visceral surfaces were then incised above the suture. The mucous layers thus exposed were then sutured with chromic catgut. The upper layers were united in a like manner, the mucous surfaces being united with chromic catgut sutures and the visceral layers by continued silk sutures, and the site of anastomosis was reinforced by a strip of omentum sutured around it.

The patient was returned to his bed. Proctoclysis of half-strength normal saline solution was given by Murphy's method, the head of the bed being elevated, with the patient in a half-sitting posture.

Twelve hours after the operation an ounce of hot water was ordered to be given by the mouth every hour. Forty-eight hours after the operation the patient enjoyed reading the morning paper, experiencing no pain whatsoever, although eructations had been persistent previous to the operation. He "did not belch" after the operation. His pulse, temperature and respiration were normal. His recovery was uneventful, and he was discharged from the hospital on January 18, 1911.

PROGNOSIS.

As to the cure of the gastric ulcer, the prognosis is fair, although complications may arise. Persistent vomiting or "vicious circle" may follow. According to some of the latest writers on this subject, there is a liability to pancreatic atrophy, with its concomitant digestive disturbances, and perhaps also the development of neurasthenia. Some advise a second operation after the healing of the gastric ulcer is complete, doing away with the gastro-enterostomy, and thus restoring the passage of food through the pyloric orifice into the duodenum again.

*A very similar case, in which surgical interference was postponed, had a severe hemorrhage in ward "A" last night, and died this morning. We must know when to operate.

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, JULY 15, 1911.

CHARGE AND COLLECT.

There is, perhaps, no class of the community that does as much unselfish and unrequited work as the physicians. They spend their days, and often their nights as well, in performing laborious, irksome, it may be, and frequently unremunerated, services. They usually continue to pursue their beneficent calling while they are able to work, and are generally stricken down with their armor on and their blade drawn for the battle. As a rule, the physician does not accumulate a large estate, and frequently he dies poor and leaves his family destitute. This should not be so, and to a large extent it is due to the neglect of the doctor in observing the most elemental principles of business. While the poor are ever with us, and it is proper to render gratuitous services to such as are in distress and poverty, nevertheless one should not get into the habit of working without compensation. The first principle of medical business should be the regular, frequent rendering of bills to those who are able to pay, remembering that it is easier to pay a small fee than a large one, and not waiting until the aggregate is large and perhaps burdensome. The professional charge should not be too small. There is a vast difference between the average fees of the lawyer and those of the physician. The lawyer expects a fee commensurate with the work done, and he usually gets it. On the other hand, the doctor usually charges ridiculously low rates for his services, and he does not collect what he charges. The people respect the successful lawyer, and pay him; they love the old family doctor, and let it go at that, if they can. The second rule of medical business, then, should be, collect your bills from those who are able to pay, or let them go elsewhere when they fall sick. This will, of course, be somewhat difficult, but when your clientele thoroughly understand that you are in earnest in demanding just and regular compensation, they will comply. The physician is a mark for all kinds of sharpers, and he is solicited to invest his money in all kinds of wild-cat enterprises. It is a good thing for the doctor when he begins to make more than his expenses to buy a home and furnish it, or, if living, in the country, to purchase a farm. Whether living in the country or in the city, it is best for him to invest in some solid security, real estate, mortgages, ground rents or attested bonds, rather than in speculative undertakings. The royal road to competence and to wealth is to spend less than you make. It is not what one makes that tells, but what one spends. The writer had no idea of inflicting this homily upon anyone when he began this article, neither is he a brilliant exponent of the efficacy of the principles enunciated above; however, he makes no charge for the advice given, and the turning loose of another class of graduates affords an opportunity for reflections and suggestions.

LOUIS McLANE TIFFANY.

Those of us who have had the pleasure of listening to the charming and instructive lectures of Prof. Louis McLane Tiffany will be glad to learn that our friend and former teacher has sufficiently recovered from his recent illness to leave for his daughter's home on the coast of Massachusetts. Dr. Tiffany was an ornament to the School, and his services were invaluable. Those who know him would deeply regret to learn that any misfortune had befallen him. His former colleagues, friends and students unite in wishing him a speedy return to his former good health.

WATCH IT GROW.

The following contributions have been made to the endowment fund of the department of pathology to July 1:

Robinson bequest	$5,000 00
Dr. Hugh Hampton Young, J. H. U.	100 00
Dr. S. J. Meltzer, LL.D., New York	10 00
Dr. Gideon Timberlake	25 00
Mr. H. P. Ohm	10 00
Dr. Samuel W. Moore, D.D.S.	25 00
Hospital Bulletin	5 00

Maryland Medical Journal	5 00
Miss C. M. Selfe	5 00
Prof. R. Dorsey Coale, Ph.D.	100 00
Dr. John J. R. Krozer, 1848	50 00
Dr. Eugene F. Cordell, 1868	10 00
Dr. Joseph T. Smith, 1872	10 00
Dr. W. J. Young, 1872	25 00
Dr. Thomas A. Ashby, 1873	100 00
Dr. David W. Bulluck, 1873	100 00
Dr. Robert Gerstell, 1873	5 00
Dr. Randolph Winslow, 1873	100 00
Dr. H. T. Harrison, 1874	5 00
Dr. Charles W. Mitchell, 1881	100 00
Dr. J. M. Hundley, 1882	250 00
Dr. Henry Chandlee, 1882	10 00
Dr. B. Merrill Hopkinson, 1885	25 00
Dr. H. C. Reamer, 1885	10 00
Dr. Frank Martin, 1886	100 00
Dr. C. W. McElfresh, 1889	100 00
Dr. Harry Adler, 1895	100 00
Dr. Jose L. Hirsh, 1895	50 00
Dr. Joseph W. Holland, 1896	50 00
Dr. R. W. Sturgiss, 1896	2 00
Dr. L. W. Armstrong, 1900	10 00
Dr. S. Demarco, 1900	50 00
Dr. M. S. Pearre, 1900	5 00
Dr. J. D. Reeder, 1901	50 00
Dr. Nathan Winslow, 1901	50 00
Dr. Arthur M. Shipley, 1902	250 00
Dr. H. C. Davis, 1902	10 00
Dr. Hugh Brent, 1903	25 00
Dr. G. C. Lockard, 1903	25 00
Dr. Geo. S. M. Kieffer, 1903	25 00
Dr. H. J. Maldeis, 1903	25 00
Dr. R. C. Metzel, 1904	10 00
Dr. Robert P. Bay, 1905	100 00
Dr. W. F. Sowers, 1906	25 00
Dr. Frank S. Lynn, 1907	25 00
Dr. E. H. Kloman, 1910	25 00
Thomas C. Basshor Company	10 00
	$7,207 00

ITEMS

Among the older alumni of the University are:

John W. C. O'Neill, 1844, Gettysburg, Pa.

R. Pinkney Blackistone, 1849, River Springs, Md.

William G. Wilson, 1852, Shelbyville, Ill.

James K. Waters, 1859, Thurmont, Md.

John J. R. Krozer, 1848, 662 West Lexington street, Baltimore, Md.

Roland H. Walton, 1850, Annapolis, Md.

Henry M. Wilson, 1850, 1018 Madison avenue, Baltimore, Md.

J. H. Jarrett, 1852, Towson, Md.

Philip S. Field, 1852, 805 North Fulton avenue, Baltimore, Md.

Thomas B. Owings, 1852, Ellicott City, Md.

Wm. E. Magruder, 1854, Sandy Spring, Md.

E. Tracy Bishop, 1855, Smithsburg, Md.

Joshua W. Hering, 1855, Westminster, Md.

John D. Cronmiller, 1856, Laurel, Md.

James H. Butler, 1857, 1508 Linden avenue, Baltimore, Md.

J. Ford Thompson, 1857, The Rochambeau, 816 15th street N. W., Washington, D. C.

Benjamin F. Price, 1857, Mount Carmel, Md.

Samuel C. Chew, 1858, Roland Park, Md.

Nathaniel G. Kierle, 1858, 1419 West Lexington street, Baltimore, Md.

Edw. F. Milholland, 1858, 115 West Franklin street, Baltimore, Md.

Somerset R. Waters, 1858, Watersville, Carroll county, Maryland.

Robert A. Dodson, 1859, St. Michaels, Md.

Theodore Cooke, Sr., 1859, 914 North Charles street, Baltimore, Md.

Benjamin L. Smith, 1859, Madison, Md.

Ephraim Hopkins, 1859, Darlington, Md.

James G. Linthicum, 1859, 1327 West Fayette street, Baltimore, Md.

Samuel Quinn, 1859, Pocomoke, Md.

Henry L. Naylor, 1860, Pikesville, Md.

John H. Coonan, 1861, 1610 Guilford avenue, Baltimore, Md.

Edw. R. Woolen, 1861, Poolesville, Md.

Charles M. Morfit, 1861, 208 McMechen street, Baltimore, Md.

Thomas B. Wilson, 1861, Edesville, Md.

John R. Uhler, 1861, McCulloh and Mosher streets, Baltimore, Md.

Charles W. Goldsborough, 1862, Walkersville, Md.

John H. Bolton, 1862, 1120 North Gay street, Baltimore, Md.

John C. Harris, 1862, 773 West Lexington street, Baltimore, Md.

W. B. Wheeler, 1862, Boonsboro, Md.

Wilbur P. Morgan, 1862, 315 West Monument street, Baltimore, Md.

Charles A. Wells, 1862, Hyattsville, Md.

John H. Chew, 1863, 23 Astor street, Chicago, Ill.

Edw. R. Trippe, 1862, Easton, Md.

Alex. H. Saxton, 1863, 1136 West Lexington street, Baltimore, Md.

James Watt, 1863, Union Bridge, Md.

George H. Brown, 1864, New Windsor, Md.

John F. B. Weaver, 1864, Manchester, Md.

Martin L. Jarrett, 1864, Jarrettsville, Md.

Wm. H. Stone, 1864, Hollywood, St. Mary's county, Maryland.

Henry C. Richardson, 1864, Great Mills, Md.

James H. Billingslea, 1864, Westminster, Md.

Joseph A. Mudd, 1864, Hyattsville, Md.

Geo. H. Cairnes, 1864, 21 West 25th street, Baltimore, Md.

Luther M. Zimmerman, 1864, Hagerstown, Md.

E. Miller Reid, 1864, 904 North Fremont avenue, Baltimore, Md.

Frank T. Shaw, 1864, Westminster, Md.

Daniel E. Stone, 1864, Mt. Pleasant, Md.

John T. Yourtee, 1865, Brownsville, Md.

Geo. W. Betson, 1865, Greensboro, Md.

G. Lane Taneyhill, 1865, 1103 Madison avenue, Baltimore, Md.

Richard W. Trapnell, 1866, Point of Rocks, Md.

John T. King, 1866, 1425 Eutaw place, Baltimore, Md.

John R. Hooper, 1866, Commonwealth Bank, Baltimore, Md.

John A. Skinner, 1866, U. S. A.

L. W. Knight, 1866, 414 South Greene street, Baltimore, Md.

Robert J. Henry, 1866, Glyndon, Md.

O. M. Muncaster, 1866, The Rochambeau, Washington, D. C.

G. G. Rusk, 1867, 2000 East Baltimore street, Baltimore, Md.

James W. Gore, 1867, Reisterstown, Md.

H. T. Rennolds, 1867, 2004 St. Paul street, Baltimore, Md.

Silas Baldwin, 1867, 700 West Lafayette avenue, Baltimore, Md.

Joseph S. Raborg, 1867, 1202 West Mt. Royal avenue, Baltimore, Md.

Junius L. Powell, 1867, U. S. A.

Benjamin R. Davidson, 1867, Davidsonville, Md.

Samuel Theobald, 1867, Cathedral and Howard streets, Baltimore, Md.

Young H. Bond, 1867, St. Louis, Mo.

B. B. Browne, 1867, 510 Park avenue, Baltimore, Md.

E. F. Cordell, 1868, 257 West Hoffman street, Baltimore, Md.

Richard T. Gott, 1868, Poolesville, Md.

Pierre G. Dausch, 1868, 124 Jackson street, Baltimore, Md.

Frank Slingluff, 1868, 1702 North Calvert street, Baltimore, Md.

Edw. H. Holbrook, 1868, 728 North Carey street, Baltimore, Md.

L. McL. Tiffany, 1868, 831 Park avenue, Baltimore, Md.

Wm. J. Newbill, 1868, Irvington, Va.

John H. Grimes, 1868, 114 East 21st street, Baltimore, Md.

J. G. Hollyday, 1868, 714 Frederick avenue extended, Baltimore, Md.

John L. Waring, 1868, Clinton, Md.

James H. Wilson, 1868, Fowblesburg, Md.

James R. Phillips, 1869, Preston, Md.

Charles B. Boyle, 1869, Hagerstown, Md.

J. McHenry Howard, 1869, Baltimore, Md.

Major Louis W. Crampton, 1869, U. S. A.

Geo. Wythe Cook, 1869, 3 Thomas circle, Washington, D. C.

W. H. H. Campbell, 1869, Owings Mills, Md.

John J. Ligget, 1869, Ladiesburg, Md.

W. J. Lumsden, 1869, Elizabeth City, N. C.

J. H. Hartman, 1869, 5 West Franklin street, Baltimore, Md.

John I. Pennington, 1869, The Marlborough, Baltimore, Md.

Zachary D. Ridout, 1869, St. Margaret's, Annapolis P. O., Md.

Joseph A. White, 1869, Richmond, Va.

James G. Wiltshire, 1869, 819 Eutaw street, Baltimore, Md.

A. Trego Shertzer, 1869, 25 West Preston street, Baltimore, Md.

Samuel H. Anderson, 1870, Woodwardville, Md.

Bolling W. Barton, 1870, Virginia.

Samuel T. Earle, 1870, 1431 Linden avenue, Baltimore, Md.

T. Marshall Jones, 1870, Alexandria, Va.

Richard H. Speight, 1870, Whitakers, N. C.

James S. Spiller, 1870, King William, Va.

Frederick Straughn, 1870, Gaston place, Jersey City, N. J.

Geo. L. Wilkins, 1870, 6 North Broadway, Baltimore, Md.

Henry A. Zeigler, 1870, 349 West Market street, York, Pa.

J. P. Cheney, 1870, Breathedsville, Md.

The following letter has been received from Dr. J. C. Perry of Ancon, Panama, in response to an appeal from the class of 1885 for aid towards the endowment of the pathological department:

June 8, 1911.

Dear Doctor: I beg to acknowledge receipt of your letter of April 11, relative to the alumni contributing towards the fund of $100,000 that the Faculty of Medicine of the University of Maryland are trying to raise for the endowment of a Department of Pathology. Your letter would have been acknowledged before this except for the fact that I have been away and have only recently returned.

I am not quite positive what would be a proper amount to subscribe to the fund, and not having acquired any vast sum of money during my professional career (although no doubt my financial condition is better than some that have graduated), I am assuming that if each alumnus subscribed $100 it ought to materially assist the fund, and I am perfectly willing and glad to give this amount.

As well as I remember, there were 80 or 90 in our class, and in all the time that I have traveled around the United States and through several foreign countries in my service position I have not met one. I am sorry for this, especially so as I knew a number of the internes who were house students at the same time that I was very well, and if you have been able to compile a list of our class, with addresses, I would appreciate it very much if you would send me a copy.

Very sincerely,

J. C. Perry.

The list of the class, which was published in the April Bulletin, has been sent to Dr. Perry.

The annual reunion and banquet of the Alumni Association of the University of Maryland School of Medicine was held at the Eutaw House June 1, 1911. The retiring president, Dr. G. Lane Taneyhill, class of 1865, presided and introduced the speakers. The Mayor had promised to be present, but being unable to keep the engagement, sent in his stead Mr. James F. Thrift, City Comptroller, who spoke from the point of view of the Health Department. Dr. Eugene A. Noble, who has just retired as president of Goucher College, gave an interesting address, with "Personal Experiences as a Co-worker with Doctors in a City Hospital" as his subject, and Dr. Charles Fiske, rector of St. Michael's and All Angels' Protestant Episcopal Church, spoke upon "The Moral Aspects of a Physician's Work." The toast to the class of 1911 was answered by Dr. Willis Linn, president of the class. Mr. Hobart Smock entertained with recitations and anecdotes, and later joined with Dr. Hopkinson in vocal selections.

The following officers were elected for the ensuing year:

President, Charles E. Sadtler, class of 1873.

Vice-presidents, George H. Stewart, class of 1899; Marshall West, class of 1901, and Samuel T. Earle, class of 1870.

Recording Secretary, Nathan Winslow, class of 1901.

Assistant Recording Secretary, William S. Love, class of 1890.

Corresponding Secretary, John I. Pennington, class of 1869.

Treasurer, John Houff, class of 1900.

Executive Committee, Drs. G. Lane Taneyhill, class of 1865; Charles R. Winterson, class of 1871; B. Merrill Hopkinson, class of 1885; George A. Fleming, class of 1884, and Vernon L. Norwood, class of 1885.

Dr. Charles W. McElfresh, class of 1889, is confined to his home with a sprained ankle.

The honorary degree of master of arts was conferred upon Dr. Eugene Lee Crutchfield, class of 1887, by St. John's College on Commencement Day, June 21, 1911.

Dr. T. Marshall West, class of 1908, of Fayetteville, N. C., was a recent visitor to the University Hospital.

Mayor James H. Preston has appointed Dr. Albert Tyler Chambers, class of 1898, a member of the School Board of Baltimore city, and the appointment has been confirmed by the City Council. Dr. Chambers was born in Virginia February 9, 1876, the son of Benjamin and Rachael Tyler Chambers. He was educated in the public schools of Virginia and the Randolph-Macon Academy. He later took a course at Eaton &

Burnett's Business College, graduating there. He received his degree of M.D. from the University of Maryland in 1898, graduating with highest honors, and winning, besides the University, the practice of medicine gold medal. Dr. Chambers is prominently connected with various professional and other institutions, and from 1900 to 1905 held the office of City Vaccine Physician. He is now professor of operative and clinical surgery at the Maryland Medical College. Dr. Chambers has a large private practice and is one of the best known of our younger alumni. The brilliant promise made in his student years has not gone unfulfilled. Dr. Chambers married on June 5, 1905, Miss Marguerite Linthicum. We consider the choice of the Mayor wise, and feel that the city can secure no man more well rounded or one who could better serve it on the School Board than Dr. Albert T. Chambers.

The following letter has been received by Prof. Randolph Winslow from Dr. Michel Hanna, class of 1910, of Tanta, Egypt:

"Tanta, Egypt, June 16, 1911.

"Dear Professor Winslow—It gives me much pleasure to write you again. It makes me feel as if I were in close contact with the University and its people, notwithstanding the thousands of miles that separate us. I recall the good time I had in Baltimore, both in and outside the University. Everything went on nicely. Give my regards to Dr. Bay. I will write to him next week.

"I would like to tell you of a few operations I performed recently. One of them was an internal podalic version for a transverse presentation; a herniotomy for a strangulated scrotal hernia; operation for a prolapsus recti, with external hemorrhoids, in an old woman; a radical operation for trichiasis by removing an elliptical piece of the cartilage, and a few other ones, such as hemorrhoids, suppurative mumps, etc. I succeeded in all of them except the prolapsus recti case, which recurred soon, though the woman is relieved from the pain caused by the external hemorrhoids.

"The case of strangulated hernia came to me 48 hours after the first symptom of strangulation. He had nausea, persistent vomiting, abdomen slightly ballooned and painful, pulse rate 120 and very feeble. I did it with George (George is Dr. George Hanna, class of 1901). I was astonished to meet a gush of fluid at the opening of the sac proper. I drained much of it and returned the bowels in the abdominal cavity after some hesitation, as they were highly congested. I thought of resorting to Murphy's button, especially as they were ready at hand; but, trusting to nature, I closed the layers according to Basini and had a perfect cure in 17 days. I used the ice cap on the abdomen right after the operation. The man was discharged in 17 days. I then remembered what you once said, answering my question in the amphitheater, 'I can do an aseptic operation even in Egypt.'

"The case of internal podalic version was in the country where decapitation seemed to me impossible and not without much danger. I gave the woman chloroform, using my handkerchief as a mask. When she was under, I turned over the anesthetic to the husband—an old farmer—and began the operation. I must say that twice I felt that I got 'stung.' But in a third trial of searching I got hold of the desired foot and thus completed the operation. I never thought the operation was so tiresome. My arm hurt me for four days.

"After all, I would like to say a few words about chloroform. I am inclined to believe either that the dangers of chloroform are very highly exaggerated or else the people of this country have a peculiar resistance against its dangers. They stand it well and practically without danger. I never thought before that the old woman with the prolapsus recti or the case of herniotomy, bad as it was, could stand chloroform. Chloroform is very advantageous in private practice. The patient sleeps in three minutes, with practically no kicking whatever. Vomiting, too, is exceedingly rare.

"George left for Europe last week via Constantinople. I am sure you will hear from him.

"I must stop now; a longer letter would bother you if this doesn't.

"Kindly offer my sincere regards to our honorable faculty, Drs. Winslow, Jr., Mr. Johnson, and to everybody that smells University of Maryland. "Sincerely yours,

"Michel S. Hanna."

Dr. William Joseph Coleman, class of 1908, has been appointed superintendent of the University Hospital, vice Dr. Piggott, resigned.

Dr. G. W. Betson, class of 1865, is located at Greensboro, Md.; Dr. G. Lane Taneyhill, of the

same class, in Baltimore, Md., and Dr. John T. Yourtree, also of the class of 1865, is at Brownsville, Md.

Dr. Sydenham Rush Clarke, class of 1905, has removed his office and residence to 423 Hawthorn road, Roland Park, Md.

Of the 44 physicians who graduated in 1870, there are apparently only the following 10 now living:

Samuel H. Anderson, Woodwardsville, Md.

Bolling W. Barton, Va.

Samuel T. Earle, 1431 Linden avenue, Baltimore, Md.

T. Marshall Jones, Alexandria, Va.

Richard H. Speight, Whitakers, N. C.

James S. Spiller, King William, Va.

Frederick Straughn, 9 Astor place, Jersey City, N. J.

George L. Wilkins, 6 North Broadway, Baltimore, Md.

Henry A. Zeigler, 349 West Market street, York, Pa.

John L. Shock, Shippenburg, Pa.

Dr. James Edward Benson, class of 1884, of Cockeysville, Md., was a recent visitor to the University Hospital.

A partial record of the class of 1865 is as follows:

John R. Hooper, Baltimore, Md.

Robert J. Henry, Glyndon, Md.

John T. King, Baltimore, Md.

Louis W. Knight, Baltimore, Md.

O. M. Muncaster, The Rochambeau, Washington, D. C.

John O. Skinner, Surgeon-General's Office, Washington, D. C.

Richard W. Trapnell, Point of Rocks, Md.

Dr. Charles W. Mitchell, class of 1881, has removed his office to 9 East Chase street, for many years the residence of the late William Pinckney White.

BIRTHS

Dr. George Carroll Lockard, class of 1903, of 1631 West Lafayette avenue, and Mrs. Lockard are receiving the congratulations of their friends upon the birth of a daughter.

Dr. Walter Franklin Sowers, class of 1906, of 2311 Edmondson Terrace, and Mrs. Sowers are being congratulated upon the advent of a daughter during the month of June.

DEATHS

The following alumni have died during the year ending June 1, 1911:

John W. Hebb, class of 1860, in Howard county, Maryland, May 18, 1910, aged 71.

John H. Stemple, class of 1901, at Conshohocken, Pa., April 19, 1910, aged 33.

Henry W. Fishel, class of 1886, at Harrisburg, Pa., May 9, 1910, aged 58.

Henry U. Onderdonk, class of 1873, at Buffalo, Wyo., May 11, 1910, aged 60.

Jesse W. Downey, class of 1869, at New Market, Pa., June 29, 1910, aged 62.

Nathaniel R. Gerry, class of 1864, at Baltimore, Md., July 2, 1910, aged 78.

Claude Van Bibber, class of 1877, at Baltimore, Md., July 11, 1910, aged 57.

Kenneth A. Blue, class of 1889, at Laurinsburg, N. C., July 16, 1910, aged 43.

Frank Camm, class of 1885, at Lynchburg, Va., August 5, 1910, aged 62.

Frank A. Gavin, class of 1874, at Baltimore, Md., August 24, 1910, aged 55.

John A. McLaughlin, class of 1888, at Clarksburg, Va., August 19, 1910, aged 50.

Martin L. Fittro, class of 1896, at New Martinsville, W. Va., August 12, 1910, aged 45.

James R. Crockett, class of 1891, at Baltimore, Md., August 2, 1910, aged 54.

Marshall J. Brown, class of 1907, at Baltimore, Md., September 4, 1910, aged 27.

John W. Dashiell, class of 1843, at Princess Anne, Md., September 4, 1910, aged 93.

William W. Sanders, class of 1861, at La Plata, Md., October 6, 1910.

Geo. C. Worthington, class of 1866, at Alberton, Md., October 23, 1910.

B. Frank Whiteside, class of 1877, at Salisbury, N. C., October, 1910, aged 58.

Jose L. Romero, class of 1879, at Jacksonville, Fla., October 14, 1910, aged 57.

Charles D. Eichelberger, class of 1868, at Emmitsburg, Md., October 19, 1910, aged 75.

Walter H. Fenby, class of 1894, at Ruthsville, Md., November 5, 1910, aged 40.

John T. Wilkins, Sr., class of 1851, at Cape Charles, Va., November 16, 1910, aged 90.

David L. Magruder, class of 1849, at Bryn Mawr, Pa., November 22, 1910, aged 85.

Thomas M. Chaney, class of 1866, at Chaney, Md., December 6, 1910, aged 68.

Berwick B. Lanier, class of 1892, at Baltimore, Md., January 1, 1911, aged 41.

Edward Lacy Gibson, class of 1894, at Staunton, Va., January 6, 1911, aged 41.

Thomas Harris Cannon, class of 1901, at Baltimore, Md., January 29, 1911, aged 31.

Charles E. O'Neill, class of 1867, at Harrisburg, Pa., December 21, 1910, aged 69.

Fenwick Robertson, class of 1854, at Pikesville, Md., January 31, 1911, aged 81.

David M. Devilbiss, class of 1872, at Woodville, Md., February 14, 1911, aged 66.

George W. Mahle, class of 1905, at Baltimore, Md., February 20, 1911, aged 29.

Hiram W. Harding, class of 1860, at Northern Neck, Va., March 24, 1911, aged 73.

Jonathan A. C. Hower, class of 1854, at Martinsburg, W. Va., March 28, 1911, aged 84.

Adolph G. Hoen, class of 1873, at Baltimore, Md., March 29, 1911, aged 62.

Jacob Dimmitt Norris, class of 1878, at Baltimore, Md., April 24, 1911, aged 67.

Frederick C. Baker, class of 1888, at East Norwalk, Conn., April 18, 1911, aged 55.

George H. Hafele, class of 1908, at Baltimore, Md., May 3, 1911, aged 32.

Cameron Piggott, class of 1882, at Sewanee, Tenn., April 30, 1911, aged 55.

Reuben A. Wall, class of 1904, at Catonsville, Md., May 4, 1911, aged 34.

Norman F. Hill, class of 1882, at Baltimore, Md., May 12, 1911, aged 64.

John R. T. Reeves, class of 1858, at Chaptico, Md., April 24, 1911, aged 79.

Richard Sappington, class of 1851, at Baltimore, Md., May 14, 1911, aged 84.

Robert Atkinson, class of 1854, at Baltimore, Md., May 22, 1911, aged 79.

Edwin G. Darling, M.D., class of 1882, died at his home at Lauraville, Md., June 6, 1911, of consumption, aged 52 years. Dr. Darling was born in Baltimore county, Maryland, and was the son of the late Isaac and Anna Darling. He had been practicing at Lauraville for about 30 years, and was well known in the vicinity. He is survived by his widow, Mrs. Virginia Darling, who was formerly Mrs. Fox, and who is a daughter of the late George Shimer of Winchester, Va. Dr. Darling's body was taken to Winchester Friday morning, June 9, for burial. Funeral services were held at Lauraville Thursday evening, June 8, and Rev. J. M. Mullan of St. Mark's Reformed Church of Baltimore, and Rev. J. J. Ringer of Andrew Chapel, Franklin avenue, officiated.

Stephen Harrison Griffith, M.D., class of 1890, of Greenwood, S. C., died at Gaffney, S. C., May 13, 1911, of heart disease, aged 44 years.

Van E. Delashmutt, M.D., class of 1854, died at his home in Shelburn, Ind., May 25, 1911, aged 79 years.

Theodore H. Beltz, M.D., class of 1863, died at his home, 320 South George street, York, Pa., May 11, 1911, from nephritis, aged 69 years.

Dr. Robert Atkinson, class of 1854, died at his home, 2105 Oak street, Baltimore, May 22, 1911, of pneumonia, after an illness of three days.

Dr. Atkinson had been in feeble health for some time, and spent last winter in Florida, returning to this city two weeks ago. Friday he contracted pneumonia, and, owing to his impaired vitality, was unable to battle against the disease.

Graduated in medicine at the University of Maryland, he practiced a few years, then founded a private school, which bore his name and which in its time was a well-known institution, ranking with the more prominent ones of Baltimore. His father, when Dr. Atkinson was yet a child, was rector of old St. Peter's Church, later founding Grace Church, of which Rev. Dr. Arthur Chilton Powell is now rector.

From his youth Dr. Atkinson had been a great church worker. He was a vestryman of Grace Church under the rectorship of his father, then Rev. Thomas Atkinson. He was a member of the diocesan committee of missions, and for a number of years had been a delegate to the Maryland Diocesan Convention. He was a student and a recognized authority upon questions pertaining to the Episcopal Church.

From 1859 until 1891 Dr. Atkinson conducted a private school for boys at Madison and Eutaw streets, in the building now occupied by the Jordan Stabler Company. Among his pupils were many men who have helped to build the modern

commercial and financial structure of Baltimore, and from his old "boys" were selected his pallbearers. He was born in Lunenburg county, Virginia, in December, 1831, coming to Baltimore with his parents in 1843.

Dr. Atkinson was twice married. His first wife was Miss Georgianna Keerl of this city. Of this marriage was born a son, Rev. Thomas Atkinson, and a daughter, Mrs. Thomas M. Nelson of Roland Park, both living. Mr. Atkinson is now a canon of the Episcopal Cathedral, in the chapel of which the congregations of the two churches of which he had been rector—Sts. Barnabas and George's—will worship. Dr. Atkinson's second wife, to whom he was married in 1874, survives him. She was Miss Laura Randall Robinson, also of this city. There were no children by this marriage.

For a half century or more Dr. Atkinson had kept in close touch with the affairs of Baltimore and in intimate personal relationship with many of the city's foremost men. Since his retirement from active life he found reading one of his chief forms of recreation. Another amusement of which he was particularly fond was chess. He was a member of a chess club, now disbanded, composed of many well-known Baltimoreans with kindred tastes.

We regret exceedingly to announce the death of Lieut. Robert H. Gantt, M.D., class of 1909, on June 10, 1911, at Fort Sam Houston, Texas. Dr. Gantt was born in Macon, Ga., January 12, 1884, the son of Mr. and Mrs. George W. Gantt, 421 Orange street. He attended the public schools of Macon and graduated from Emory College in 1902. He attended the Atlanta Medical College for two years and then spent two years in Macon as a prescription clerk with two well-known drug houses of that city. In 1905 he entered the University of Maryland, graduating in 1909. He then spent a year as interne in a Baltimore hospital and was afterwards appointed to the Soldiers' Home. Just a year ago he was assigned to the Medical Corps, U. S. A., and when the troops were ordered to Texas he was stationed at Fort Sam Houston. Death was due to a nervous breakdown. Dr. Gantt was well known and much liked in Macon, and the news of his death was received with deepest regret. He was buried in Macon. He is survived by his parents, three brothers, George W. Gantt, Jr., J. A. Gantt of the Atlanta Tech. and Ben Jones Gantt, and one sister, Miss Annie Gantt.

G. E. Milton Smith, M.D., class of 1888, of 594 Presstman street, Baltimore, died at the Church Home and Infirmary May 22, 1911, aged 43 years. Dr. Smith is survived by his widow, Mrs. Margaret M. Smith. He was buried from Christ Church, Baltimore, at 4.30 P. M. Tuesday, May 23, 1911.

LABORATORY REPORT OF THE UNIVERSITY HOSPITAL.

Month of June.

Blood Examinations.

Leucocyte counts	158	
Erythrocyte counts	24	
Differential leucocyte counts	10	
Hemoglobin determinations	81	
Smears for malarial parasites	10	
Blood cultures	5	
Wasserman tests	41	
Widal tests	11	
		340

Urine Examinations.

Routine urinalysis (chemical and microscopic)	395	
Total estimation for urea	4	
Total estimation for albumen	5	
Total estimation for sugar	4	
		408

Miscellaneous.

Gastric contents (chemical and microscopic)	11	
Feces (microscopic, etc.)	10	
Sputum examination	15	
Bacteriological cultures and smears (from operative cases)	10	
Smears from vagina and urethra (male)	12	
Spinal fluid examination	2	
Pleural fluid examination	3	
Autopsies	2	
Section of tissue for microscopic examination	15	
		80
Total		828

Dr. J. L. Hirsh,
Dr. H. J. Maldeis,
Dr. R. C. Dodson,
W. M. Scott.

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THE RELATIVE VALUE OF CECOSTOMY AND APPENDICOSTOMY IN THE TREATMENT OF AMEBIC DYSENTERY AND OTHER DISEASES AFFECTING THE MUCOUS LINING OF THE CECUM AND COLON, WITH REPORT OF CASE.

By Richard C. Dodson, '11,

Senior Medical Student.

After carefully searching the medical literature I find that Prof. Samuel Goodwin Gant of New York was the originator of the operation which, for the want of a better name, he called "Cecostomy." This was in 1903. I also found that during the same year Holton C. Curl, M.D., U. S. A., surgeon at Colon Hospital, reported a few cases in the *Annals of Surgery*, Vol. LXIII, p. 543.

The operation of cecostomy for amebic dysentery is not always advisable, especially in the late cases where there is prostration and great damage to the mucous membrane and submucous tissue. In the early cases it can be controlled by irrigation per rectum, combined with proper diet and rest.

There remains an intermediate class of cases in which ordinary treatment is unavailing, where there is an increasing number of stools daily and, although considerable strength remains, the patient is weakening. These cases grow worse, and death is usually the result. This is the only case, in my judgment, in which the operation of cecostomy is justifiable.

The results at the Colon Hospital were very favorable, Dr. Curl reporting eight cases of partial or total recovery out of 11. He also reports three cases of relapse which cleared up under irrigation. In one case, in which there was clinically a complete cure, an opportunity was afforded for an autopsy by the death of the patient from beri-beri three months later. The gut was found in excellent condition, the sinus being closed, and there was a broad, firm attachment of the cecum to the abdominal wall.

The following case was operated upon by Prof. Samuel G. Gant, M.D., LL.D., of New York, at the University Hospital on April 27, 1910, for amebic dysentery:

Name, W. R.; white; man entered hospital on March 31, 1910; age, 25 years; occupation, British seaman; family and past history of no importance; complaint, dysentery.

Present Illness.—About five years ago, while in Chili, he developed dysentery. This attack laid him up for about a week, and during his illness he took chloranodyne. He had six or seven movements a day. Feeling better, he went on duty, and enjoyed good health until he reached Dunkirk, France. After being on shore for some time his dysentery returned. A chemist gave him something, after which his movements were irregular, being about one or two in a week.

Eight months previous to entering the hospital, while on the Black Sea, his movements became more frequent, amounting to six or seven per day, with the passage of blood. These movements were irregular, and would ease up for a day or two and then return. During movement he had straining and pain in the rectum. He was also unable to sleep. After reaching Rotterdam he stopped working, and was laid up for about 12 days, during which time he had from 15 to 20 movements per day, composed of water and blood, accompanied by much straining and pain. From here he went to England, and upon seeing a doctor was advised to go to an infirmary, where he was given some medicine which put him in better

health than he had been for five years. He then set sail for the Canary Islands, and from there went to Spain, where he was taken sick again. His movements were from 20 to 30 a day, passing slime, blood and water, with pains in the stomach and great weakness. Then he came to Baltimore, and was brought for treatment to Dr. F——, and was advised to come to the University Hospital. The medicine given to the patient by Dr. F—— improved him, but shortly after entering the hospital he became worse, his bowels moving 13 or 14 times per day, with blood. During this time he lost about 20 pounds in weight. He has suffered from veneral disease, but not syphilis.

Physical Examination at Time of Entrance.—At time of examination patient is in dorsal decubitus, showing no evidence of pain. Head covered with a good crop of black hair. Forehead negative. Eyes, pupils react to light and accommodation. Left pupil slightly larger than right. Ocular motion good. Conjunctiva pale. Sclera clear. Nose and ears negative as to discharge. No tophi nor mastoid tenderness. Mouth, tongue protrudes in median line; no coating, but of flabby character; teeth in poor state of preservation. Pyorrhea alveolaris marked. Pharynx shows some congestion. Neck rather long; no abnormal pulsations; no tracheal tug; no glandular enlargement. Chest slightly emphysematous; expansion good and equal on both sides. Percussion reveals hyperresonance over entire front. Palpation negative. Auscultation reveals the breath sounds somewhat roughened, inspiration slightly prolonged over entire front. No rales. Back negative, except slight hyperresonance and an occasional mucus rale in left apex and base. Heart, A. C. D. decreased to the right of the left nipple. Begins at third rib and extends to the fourth rib. P. M. I. visible and palpable in the fourth interspace one inch to the left of sternal line. Sounds at apex rather snapping in character, but regular. Second pulmonic and aortic snapping; no murmurs or thrills.

Abdomen.—Costal angle narrow; liver dullness begins at fifth interspace, and extends to one finger's breadth below the costal margin. Abdominal walls relaxed; no areas of tenderness noted; no palpable masses. Genitalia, no discharge, occasional palpable gland; scar in left groin resulting from bubo. Extremities, reflexes normal; slight edema of anterior tibial region. Scabs noted on right tibia result of trauma. Upper extremities, no glandular enlargement; no arteriosclerosis; pulse 110; volume and tension minus; rhythm good; no dicrotism.

Proctoscopic Examination, by Dr. J. D. Reeder. Examination with six-inch tube reveals mucus and blood in large quantities. Entire rectum injected and edematous. Microscopic examination of mucus shows amebi coli in great numbers. Scrapings from ulceration shows the following: Blood corpuscles, phagocytical amebæ histolytica, trachanonis intestinalis. Urine, light amber; acid reaction; Sp. Gr. 1035; albumen and sugar negative; indican large amount. Microscopically, epithelial cells; large number of leucocytes; no casts. Leucocyte count, 18,400; red cells, 3,900,000; Hgb., 60 per cent. Differential count, polymorphonuclear neutrophilees, 73 per cent.; small mononuclears, 4½ per cent.; large mononuclears, 9½ per cent.; eosinophiles, 11½ per cent.; transitional, 1½ per cent. Stool positive to ameba coli.

Treatment.—Tinct. ferri chloridi gtts. X. t. i. d. Rectal irrigations twice daily of warm water, fluid extract krameria oz. 2; salol grs. 5 every three hours. This treatment was continued until time of operation. After the operation he was irrigated twice daily with potassium permanganate 1-10,000 and then 1-5000. He recovered after some difficulty. The sinus closed, and patient left hospital cured.

Operation—Cecostomy.

Operator—Prof. S. G. Gant.

Assistant—Dr. Fred Rankin.

Anesthetist—Dr. R. P. Bay.

Anesthetic—Ether, by the drop method.

Patient was taken to the operating-room and prepared for an aseptic operation. Through a two-inch intermuscular incision made directly over the cecum, it and the lowermost part of the ileum are withdrawn and the edges of the wound covered with gauze. The anterior surface of the cecum is scarified after the ascending colon and ileum have been clamped to prevent soiling of the wound when the bowel is opened. Four linen seromuscular pursestring sutures are introduced into the anterior wall of the cecum opposite the ileocecal valve; the bowel is opened inside the suture line. The gut is grasped at the junction of the large and small intestine, and held in such a way that the ileocecal valve rests between the thumb and finger of the left hand. A Gant catheter is then passed directly across the cecum and through the ileocecal valve into the small intes-

tine, aided by the thumb and fingers. The obturator is removed from the guide, and a catheter is introduced in the small bowel and held there by an assistant until anchored to the cecum by catgut sutures to prevent slipping out during operation. A short rubber tube three inches long is projected into the cecum for an inch or more and anchored beside the one projecting into the small gut. The enfolding pursestring sutures are now tied, forming a cone-shaped valve about the catheters to prevent leakage of gases and feces. After removal of the clamp the cecum is scarified and anchored to the transversalis fascia, denuded of its peritoneum, by through and through linen suspension sutures. The suspension sutures are tied across rubber tubing and wound closed by the layer method. Catheters are fastened by stitching or by encircling them with an adhesive strip to hold them together, and crossing this at a right angle a second piece of plaster, placed between the pipes to prevent their slipping out. The ends of the catheters are closed with cravat clamps to prevent leakage, and the operation is completed by applying the dressings about the projecting tubes. One tube is left longer than the other, or is identified in some way in order that the interne or nurse may know which is in the large and which in the small intestine when the time for irrigation arrives. To avoid danger of infection, treatment is not begun before the fifth day, except when urgent.

The operation for appendicostomy is as follows: The appendix is approached through a gridiron incision, and located by tracing the anterior longitudinal bands downward, when it and the cecum are freed, brought outside and the wound protected with gauze. The cecum is drawn first to one side and then to the other by an assistant, while the parietal peritoneum is removed at the sides of the incision to insure union between the gut and the transversalis fascia. The appendix is freed and straightened by ligating and dividing adhesions and the mesentery at a safe distance from it. But when the appendix is free the mesentery is not disturbed. After the cecum has been scarified two seromuscular suspension sutures are introduced into it at the sides and near the base of the appendix, each taking three bites in the gut. By means of a long-handled needle the anchoring stitches are carried through the abdominal wall and clamped with forceps for identification. Having surrounded the appendix with gauze, a traction suture is introduced to steady it while it is being amputated and cauterized. A Gant probe-pointed appendicular irrigator, closed with a stopper, is introduced, and the appendix is ligated around it above the projecting rim. The appendix is placed at the lower end of the wound, pointing upward and anchored by two gut sutures, which pass through the transversalis fascia. The abdominal layers are then approximated separately, after which the cecal suspensory sutures are tied across rubber tubes. The irrigator is prevented from slipping out by the adjustment of adhesive straps, or by means of attached pieces of tape which encirle the body. In urgent cases, from one to three pints of warm saline solution are immediately injected into the colon when the irrigator stopper is introduced to prevent leakage. The wound is sealed by means of cotton and collodion, and is protected further by rubber-covered split gauze pads, which overlap each other when placed about the appendix. The end of the irrigator is surrounded by twisted gauze strips to prevent pressure upon it when the outer dressings are applied.

The advantages of the former operation, namely, the Gant's cecostomy, which provides a means of irrigating both the large and small intestine, are as follows:

1. Owing to the fact that the cecum lies against the inner abdominal parietes, it can be easily anchored without angulation or twisting the bowel.

2. Since the opening is opposite the ileocecal valve, a catheter can be introduced into the small bowel for irrigating or siphoning off its contents for examination.

3. The cecal opening can be made of a suitable size. The circular valvelike projection formed around the catheter by the unfolding pursestring suture prevents leakage.

4. The catheter can be changed without difficulty.

5. Closure of the opening follows withdrawal of the catheter and a few applications of the copper stick or cautery.

6. Owing to the natural position of the cecum, there is less tension and pain following its anchorage to the abdomen than occurs after appendicostomy.

7. Cecostomy (Gant's) may be employed in the treatment of lesions located anywhere in the

intestinal canal, while appendicostomy is limited to those of the colon.

Disadvantages of appendicostomy:

1. The appendix is more difficult to bring up for anchorage than the cecum, because of its deeper and more uncertain position, and because it is frequently bound down by adhesions or short mesentery.

2. Anchoring of the appendix causes angulation or twisting of the cecum, which, in turn, may induce constipation, discomfort or pain.

3. When the cecum about the appendiceal base is caught in the wound it induces nausea.

4. When the appendix is small, short, strictured, bound down by adhesions or is otherwise diseased, it is useless for irrigating purposes.

5. Irrigation is frequently difficult and unsatisfactory because of the small appendiceal outlet.

6. Pain following appendicostomy is much greater than after cecostomy, owing to the pulling upon the appendix by the loaded cecum, the periappendiceal adhesions or squeezing of the attached mesentery when the wound is closed tightly about it.

7. Frequent dilatation or insertion of a catheter is often necessary to keep the opening sufficiently large.

8. Death has followed injection of irrigating fluid into the abdomen beside the appendix where an interne mistook an opening in the wound for that of the appendix.

9. After cure it is more difficult to close the appendical than the cecal outlet, and an appendectomy may be necessary.

10. Appendicostomy frequently fails, because the appendix slips back into the abdomen or retracts sufficiently to make irrigation almost or quite impossible.

11. The appendix has been known to slough off several times owing to tension, its constriction by the sutures or destruction of its blood supply, making cecostomy imperative.

12. Appendicostomy is not effective when the disease is located in the small intestine.

13. Appendicitis requiring appendectomy following closure of the appendiceal outlet has occurred.

14. Owing to the irritation caused by the catheter or treatment, the mucosa may become so inflamed and swollen, ulcerated or strictured, that irrigation must be abandoned.

15. According to Reed, the catheter causes the wall of the appendix frequently to perish.

16. Finally, the appendix may become blocked by angulation.

Summary.—In intermediate cases in which there is still a reasonable amount of strength, but where treatment is not controlling dysentery, the operation of cecostomy with irrigation of the intestine with quinine solution is indicated.

Cecostomy is preferred to appendicostomy because of less sloughing and easier closure of the fistula. The appendix should be removed at the time of fastening the cecum to the abdominal wall.

A rapid improvement usually follows the beginning of irrigation, but convalescence is slow, and at times difficulty is experienced in closing the fistula.

The after-treatment is tedious, and the patients are offensive cases to have in wards.

All in all, it is the lesser of the two evils, but in my opinion it saves lives in selected cases.

SPINA BIFIDA—ITS PATHOLOGY, DIAGNOSIS AND TREATMENT.

By B. S. Boyer, '11.
Senior Medical Student, University of Maryland.

Spina bifida occurs once in about 1000 births; oftener in females than in males. It is a congenital hernia of the spinal membranes, sometimes of the cord, through a cleft due to the absence of some of the vertebral arches. Etiology is unknown, but the best explanation is that of an imperfect separation of skin and medulla in embryonic life. (Ranke.)

Pathology.—The defect may be confined to one arch, or may involve many; rarely all. The fusion of the laminae commences in the upper dorsal region, extending in both directions; its failure to close causes a median posterior defect, which is most common in the lower part of the spine, where the sacral laminae are the last to solidify. This accounts for the frequency of this condition here rather than in other regions of the spine. From this defect in the skin and the low resistance it serves as a starting point of inflammation, and by extension a fatal meningitis is caused. There is also a lack of development or secondary destruction of the cord, causing paralysis of the lower limbs, sphincters, bowel and bladder disturbance and associated clefts. Therefore, such

infants are rarely, if ever, viable, and many are "still born."

Varieties.—The nomenclature of spina bifida is divided into three main varieties:

(I) Spinal meningocele, where the spinal membranes alone protrude in the sack.

(II) Myelomeningocele; the cord and membranes both protrude, fluid collects, distends and forms a globular cavity of large size; sack has wide base, flat contour; contains nerve roots; flattened cord or cauda equina in the sack.

(III) Myelocystocele; the fluid is in the central canal, and the inner lining of the sack is formed by the meninges and thinned-out spinal cord. Fluid collects in the central canal and distends it; skin and sack closely adhere, and atrophy results from the effect of pressure; circumscribed loss of epidermis is apt to occur, and may perforate the sack. This variety is often combined with deformities of the body, spine and feet. In all three the fluid is cerobro-spinal, and, as a rule, there is a cleft in the bony canal and dura.

Symptoms.—Apart from the presence of a tumor, many cases give no symptoms, although we have more or less paralysis of the rectum and bladder; sensory disturbance of lower extremities, may have abnormal conditions, as hydrocephalus, clubfoot or defects elsewhere. Frequently the bony cleft cannot be felt, due to size or tension of the tumor, but in such cases the X-ray will reveal its absence.

Diagnosis.—The congenital origin, position of tumor filled with fluid where tension varies with posture and expiratory efforts, render the diagnosis easy. The differential diagnosis of these tumors is more difficult, and at the same time is of greater importance from a prognostic and treatment standpoint, but until an incision is made it is often impossible to make an accurate diagnosis with certain evidence and firm foundation. In myelocystocele, by pressure on the tumor, we get a more decided and prompt swelling of the fontanels; cleft is small, narrow, involving one to three vertebræ; sensory disturbance in the lower extremities is more common; skin shows ulcerations or thin scars; paraplegia, paralysis of sphincters and other deformities are more often present. In meningocele the tumor is almost always over the sacrum, has a small pedicle and bony cleft, and absence of all symptoms except the local. Opening the sack we find the presence of nerve trunks. Myelomeningocele has a broad base, irregular and thin ulcerated covering, and a shadow may elicit the presence of nerves and cord in the sack.

Prognosis.—In general, all cases are unfavorable. Fortunately, most cases die early within the first few weeks. If not operated upon, few live to be over five years of age, the mortality averaging about 94 per cent. in the first year. Usually the tumor increases in size, the skin ulcerates, the sack perforating, and infection of the meninges terminates in death. If the patients survive the first few weeks, by paralysis of the bowels and bladder there is a constant danger of urinary sepsis, threatening life. Most cases living five years or more are meningocele, which is the most favorable variety, myelocystocele being next.

Treatment.—Many cases demand only palliative treatment; the condition is incompatible with life, and unless relieved death occurs within the first few weeks. Pressure to prevent increase in size should be instituted with caution, if at all, and only when the skin is normal, owing to the liability of ulceration. Keep the surfaces clean, dry, and protect with cotton and sterile vaseline. If suitable for radical operation later on, aspiration may be instituted to prevent rupture and diminish the pressure. The needle should be inserted close to the base, where the skin is healthy and thick, and directed obliquely to avoid the injuring of nerves. Aspiration alone is useless, and later proves fatal. Efficient results have been reported by Morton in those cases where operation is contraindicated in which, by aspirating one to two drachms of fluid and then injecting one-half to one drachm of fluid in, composed of iodin grs. X, iodid of potass. grs. XXX, glycerine ounces I, a repetition of the injection being required every 10 days for two or three doses. Among the 71 cases in the London Clinical Society, a mortality of 38 per cent. was reported, while Morton's own statistics showed a mortality of 15.3 per cent. Cure results from adhesions of the sack wall due to the inflammatory reaction. In the hands of the other clinicians it has been found somewhat inefficient, and should only be resorted to in such cases where operation is inadvisable.

At present operations are almost exclusively used. Opinions differ as to age, contraindications and operability of various forms.

Hydrocephalus, marked paralysis, loss of sphincter control and deformities, as talipes, etc., are considered by most surgeons as contraindications to operation. But it must be considered that

an unfavorable result from the operation is no worse than is to be expected without operation, and if by operating it is possible to cure, or even improve, the condition, it is regarded by others as justifiable, as without operation they succumb to secondary infection, or, if they live, their condition is such that life is a continual burden to them throughout.

Age.—Authors differ here from operating as early as possible to after five years. Operations on children under five years have an enormous mortality (35 per cent.), but after five years operations are comparatively safe (4.7 per cent.). If we wish to reduce the mortality and improve the symptoms, we must operate within the first year. Lovett (1907) reported a case of successful operation immediately after birth. After the fifth year there is no hope of improving the paralysis, so that late operations have no effect outside of removing the local tumor. If tumor is not rapidly enlarging, and is covered with sound, thick skin, it is not advisable to operate.

Operation.—Chloroform is the best anesthetic. The hips should be slightly elevated and body kept warm by hot blankets or water bags. Carefully clean the skin, and, if ulcerated, sterilize by carbolic and follow by alcohol. The incision should be made at the side, and after entering the sack replace the nerves in the vertebral groove and dissect away the redundant and ulcerated tissue. Special devices for closing the bony defects to prevent recurrence is unnecessary, as, unless we have complicating it hydrocephalus or infection, there is little or no tendency to recur. If hydrocephalus, the operation is contraindicated, and one should, at the present date, avoid infection. Merely covering the cleft with lateral flaps of muscle and facia and suturing is sufficient. The quickness of operating and best technique in these cases gives the most favorable results, as patients cannot stand long operations, and it lessens the danger of infection. Finally, suture the skin, which should be done to one side, and not directly over the sack; drainage is not necessary if aseptic precautions have been followed, and unwise, as it favors infection. The wound should be dressed with the greatest care to prevent soiling and infection. Collodion or rubber tissue should be used, combined with frequent changing of outside dressings and napkins.

Results.—If all cases are followed up and reported, the total mortality, a few weeks after operation, would aggregate fully 50 per cent., the cause of death being shock, meningitis, hydrocephalus and septic infection. With the report of a high mortality and the statistics to show some complete cures, it should not deter us from attempting surgical relief.

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AUTOENUCLEATION OF FIBROMA COMPLICATING PREGNANCY.

By J. A. Devlin, M.D., 1906,
Gynecologist to the Northern Dispensary; Surgeon to Hudson Street Hospital, O. P. D.

The comparative rarity of the case I will describe leads me to believe that a report on it will be of interest to The Bulletin readers.

In November, 1910, I was asked to see a primipara, 35 years old, who was supposed to be in her eighth month of pregnancy.

Five days before I began to attend her she had a sharp hemorrhage, which her physician managed to control with difficulty, and fearing that she had a placenta previa, advised her to go to some hospital. This advice was not followed out, and as the physician then refused to have anything further to do with the case I was asked to give my opinion.

Examination and personal history revealed to me that I had a dead fetus to deal with in a uterus which had a firm mass about the size of a large cocoanut in the anterior and middle portion of the body of the uterus.

On explaining the nature of the complication, the woman was easily prevailed upon to enter the hospital, and the same evening I introduced a uterine bougie well into the cavity of the uterus and packed the vagina tightly with sterile gauze. The following morning the gauze was removed and a cleansing iodine douche was given, the bougie remaining in place.

At 5 o'clock that afternoon she had active labor pains and a six-months' macerated fetus was de-

livered. Its skull showed marked evidence of pressure from the tumor.

As all pains ceased after delivery of the fetus, and owing to the position of the now definite fibroma, which precluded the Credè method of placental expression, I inserted my hand into the cavity of the uterus to remove the placenta and examine more thoroughly the tumor, which I found to be submucous.

The patient was then returned to bed in good condition, as there was practically no hemorrhage, and a waiting policy adopted. For 24 hours after the patient had normal pulse and temperature and sanguinous discharge. On the second day, however, her temperature rose to 101°, and the discharge became more profuse and foul in odor.

As I was perfectly confident that there were no retained secundines, I attributed the rise in temperature and profuse discharge to beginning disintegration of the tumor mass, which by the rapid contracture of the uterine musculature was deprived of its blood supply. Frequent vaginal douches were given to ensure cleanliness, and on the fifth day I removed from the cavity of the uterus several large pieces of the sloughing tumor which were forcing themselves through the cervix. This removal of loose pieces of tissue was done every day for five days. On the fifth and last day I removed two pieces, each about the size of a large orange. An intrauterine douche was given, and on sweeping my finger over the uterine cavity I could find no more evidences of the fibroid, which had sloughed out, but there was a small one in the posterior wall intact, about the size of an English walnut. This one I left alone, not considering it wise at this time to attempt enucleation.

The following morning the patient's temperature was normal and remained so thereafter, the horrible discharge entirely absent, which was a profound relief to the patient and her attendants, I assure you.

Subsequent examination in my office showed the uterus slightly retroverted but perfectly movable. A small, hard nodule could be felt in the posterior wall just above the cul-de-sac. The adnexa were normal.

In conclusion, I might say that if this woman becomes pregnant again she will more than likely have difficulty, as I am sure there are more small fibroids in the body of her uterus only waiting for an increase in nourishment to increase in size.

A BACTERIAL ROT OF ONIONS CAUSED BY BACILLUS COLI.

By A. W. Giampietro, M.D., 1907.
Laboratory of Plant Pathology, U. S. Department of Agriculture; University of Maryland, 1907.

In August, 1910, specimens of onions were received by the writer from Mr. Benj. Hartzell of Shepherdstown, W. Va., affected with a soft, granular, greasy, dark-greenish rot, emanating an offensive odor. In cutting through the specimens it was noticed that sometimes one scale was totally rotten from top to bottom and entirely around the bulb, while the adjoining scales on either side remained sound. Cases were also found in which two or more scales were affected, while intervening or adjoining ones were healthy. Generally the rot extended from the upper part downward toward the root end, although in some cases the whole bulb was involved, being particularly soft at the lower end.

Several sets of plates were poured from this material and out of numerous colonies, which appeared after an incubation period of 12 to 18 hours at room temperature, pure cultures of five distinct colonies were transferred to beef bouillon, from which another set of plates was poured, in order to ascertain the purity of each colony, and final transfers were made on beef agar. The five cultures were marked Nos. 1, 2, 3, 4 and 5, respectively.

Using very sound onions, obtained in the open market, inoculations were made under the most antiseptic conditions. Some specimens were inoculated by puncturing in two or three places on the same scale with a platinum needle infected with a 24-hour-old culture of the organism; some were punctured on several scales, leaving several uninoculated scales between them, and still other onions were inoculated by having the infected platinum needle smeared over all the cut surface. The sets of inoculations, consisting each of six inoculated onions and two controls, corresponded to the number of pure cultures to be tested.

The inoculated specimens were kept under bell-jars at room temperature, and every other day a few drops of sterile distilled water were poured on each onion from a sterile pipette.

The onions inoculatd with cultures Nos. 2, 4 and 5 began to rot after one week, and in each

case about three-quarters of the bulb was rotten at the end of the fourth week.

Cultures Nos. 1 and 2 showed negative results, and were, therefore, discarded.

Four sets of plates were poured from the positive inoculations and two pure cultures isolated from each of the colonies appearing in each set of plates. These pure cultures were further tried on sound onions, and produced the same rot which affected the onions originally received from West Virginia. They were, therefore, retained as the exciting cause of the disease.

Reviewing the available literature on this disease, it will be found that F. C. Stewart of the New York Experiment Station first described the malady in 1899, and his reference to the organism supposed to be the cause of the disease is summarized as follows:

"Microscopic examination of the rotten tissue shows entire absence of fungi, but there are swarms of a medium-sized motile bacillus, which is without doubt the immediate cause of the rot."

Sorauer, discussing the bacterial diseases of the onion, attributes this rot to a motile bacillus, but, in view of its polymorphous aspect at different times, he concludes that the trouble is probably due to a complication of diseases. Quoting his words:

"From this fact it appears with certainty that we are not concerned here with one disease, but with a rot disease in which several species of bacteria take part."

His failure to reproduce the disease on sound onions kept in inoculated water cultures led him to conclude that the disease is due to a saprophytic micro-organism present in the soil, which becomes parasitic on wounded onions. In this connection he says:

"Possibly we are concerned here with a disease in which harmless soil bacteria become parasitic after a previous wounding of the onions and a subsequent excess moisture of the soil."

The late Dr. George Delacroix in 1906 published a paper entitled "Sur la maladie appalee Grass de l'Oignon," in which, after describing the disease, he asserts that it is caused by a bacillus—a non-motile gas producer, which is decolorized by Gram's stain, and which he named *Bacillus cepivorus*, n. sp., George Delacroix. This bacillus, according to Delacroix, does not require a wound to produce infection. He says:

"Infection is produced easily by means of rotten pulp or cultures, and on young scales placed in a moist place penetration (by the organism) is accomplished without wound."

That all three investigators refer to the same disease is evident from the fact that the description first given by Stewart has been followed by Sorauer and Delacroix. Sorauer refers to Stewart's published description of the malady, and Delacroix acknowledges and cites the publications of both Stewart and Sorauer.

In view of these meager and contradictory statements, a special laboratory investigation of the disease was begun, with the hope of definitely determining the causative organism.

A study of the morphological and the physiological characters of the organism confirmed the findings of Stewart and Sorauer as to its motility. It was further ascertained that it did not stain by Gram's method, produced gas and indol on standard media, and presented other characteristics pointing to its unmistakable relationship with *B. coli*. To definitely establish this relationship and possible identity, a pure culture of *B. coli* was obtained from Mr. J. H. Johnston, formerly an assistant pathologist in the United States Department of Agriculture. This pure culture was a transfer made by Prof. Theobald Smith from his stock culture No. 15.

A comparative study of the onion rot organism and *B. coli*, both on artificial media and by inoculations on sound onions, was then begun. Numerous parallel experiments with the two organisms, producing identical results, have convinced the writer that *Bacillus cepivorus* is the same as *B. coli*. Both organisms are polymorphous, and are motile, having peripheral flagella; both are decolorized by Gram's stain, produce gas on suitable media, produce indol, reduce nitrates, coagulate milk slowly, and grow best on alkaline media. Neither liquefies gelatin. The optimum temperature for each is 37 degrees C., and their thermal death point 4-5 minutes at 60 degrees C. Each produces rot on sound onions, and can be recovered in pure cultures from the diseased host (onions).

In addition to the laboratory tests, inoculations were made on healthy onions growing in pots and in water cultures, and also on cocoanut palms in the greenhouse, with results proving the findings of Sorauer, that the occurrence of the disease is *secondary* to the infliction of a wound. Physio-biochemical studies of these bacilli on artificial media were also conducted. These latter tests revealed the identity of *B. coli* and *B. cepi-*

vorus by pointing to the identical production of cellular activities of both organisms, as shown in their products of fermentation (gas, ethylic alcohol and lactic acid), indol, reduction of nitrates, and non-liquefaction of gelatin.

A special biochemical study of both organisms in connection with the production of gas and indol and in relation to the liquefaction of gelatin is being continued for further proof of their identity, and detailed results will be published as soon as the work is completed.

"STRICTURE OF THE DEEP MALE URETHRA OF SMALL CALIBER."

By J. C. Wilkins, '11, Senior Medical Student.

A stricture of small caliber in the deep urethra is a narrowing of the lumen of the urethra below the size of a No. 18 French sound, at or posterior to the bulbo-membranous junction.

There are three varieties of stricture well recognized by the history, symptoms and physical findings:

I. Inflammatory;
II. Spasmodic, and
III. Organic.

I. Inflammatory stricture is produced by soft, inflammatory cellular infiltration, which may become absorbed, or may go on to exfoliation of the mucous membrane and scar tissue formation, and form a true organic stricture. It is nothing more than an inflammatory, edematous and congestive swelling, enough to almost obstruct the passage of urine.

II. Spasmodic stricture often contracts so small as to be classed as stricture of small caliber. It is not truly a stricture, but has to be dealt with and differentiated from organic stricture. It is due to the contraction of the periurethral bands of muscle or bands of connective tissue found as a result of some inflammatory process. This reflex spasm arises from a urethritis, erosions of the urethra, hemorrhoids, prostatitis, and fistula, or any injury to the pelvic organs. Spasmodic strictures relax by the administration of morphia and the passage of a sound against the stricture with gentle pressure. The treatment is to remove the exciting cause and prevent any complications from arising until the cause is relieved.

III. True or organic strictures are those due to a previous urethritis in the vast majority of cases, especially in those cases in which the urethral inflammation has reached an exceptionally high grade of intensity, or which have run a very protracted course. However, quite a few result from trauma received from injuries to the perineum or lacerations of the mucous membrane by rough, unskillful instrumentation, which produces the well-known "false passage." The pathological condition varies from a simple induration and thickening of the mucous membrane with connective tissue, proliferation occurring in its depths, to the exfoliation of the mucous membrane and formation of a dense mass of cicatricial tissue occupying the submucous region and deeper structure of the urethral wall, which contracts and produces a permanent dense hard band or mass of scar tissue. In the traumatic variety the process is similar to the inflammatory variety in the end result. The laceration heals by round cell infiltration and cicatrization. The mucous membrane posterior to a small caliber stricture is always the site of a chronic catarrhal inflammation, which gives rise to a gleety discharge. A chronic prostatitis is usually associated with those of long standing, especially the inflammatory variety. As a result of the use of non-sterile catheters and non-aseptic technique of catherization, a cystitis is almost sure to be set up.

Stricture of small caliber so markedly interferes with the passage of the urine that there is produced an atony of the bladder by retention, and atony of the bladder predisposes to cystitis, which has a tendency to extend to the ureter and finally to set up a pyelonephritis and uremia.

Symptoms and Diagnosis.—The symptoms depend to a great extent on the complications associated with this condition. In most cases a history of a chronic gonorrheal urethritis or trauma will be gotten. The insidious onset following a urethritis is of importance. It often takes two years for an organic stricture to develop after the initial exciting cause. Frequency of urination at first is due to congestion and inflammation of the urethra posterior to the stricture or verumontonitis, prostatitis or cystitis; later, frequency of urination may be due to atony producing retention and dribbling. Distortion of the stream is very characteristic, being very small, twisted or forked. It requires a longer time for the patient to void his urine, the force being so much lessened. A gleety discharge, composed of muco-pus and shreads in

the urine, due to the chronic catarrhal inflammation of the urethra posterior to the stricture point.

Acute retention is a common occurrence following exposure to cold and wet, alcohol and sexual excesses, which produce either congestion of the stricture or a spasmodic contraction of the stricture entirely occluding the lumen of the urethra. Pain along the urethra is variable. Sexual functions are markedly interfered with. At times the semen may be kept posterior to the stricture for some time. In addition to the above symptoms, the diagnosis is completed by scrubbing of the external genitalia with soap, water, and applying bichloride of mercury, alcohol and sterile water. Then irrigate the urethra with potassium permanganate 1-6000, followed by hot normal salt solution. Select a metal sound or a flexible wax bougie à boule, No. 20, French, and pass it down to the stricture, where it will stop and refuse to pass. By measurement of the instrument used and palpating the end of the bougie through the perineum, one can estimate fairly accurately the location of the stricture, which is surgically most important. If the stricture is not complete it will be possible to pass a filiform, which in those cases complicated by acute retention insure no disastrous results to follow, as the urine will trickle by the side of the guide.

Treatment.—The treatment of stricture of small caliber in the deep urethra as in the pendulous urethra is divided into (1) dilation and (2) some form of urethrotomy, either internal or external.

Dilatation is the treatment of choice, provided the stricture is applicable to such a conservative means. When there is a stricture of short duration, soft and dilatable, regardless of its location and size, it should not be cut, but dilated by systematic passing of sounds. Inflammatory and spasmodic strictures are especially amenable to dilatation; at the same time the cause should be vigorously treated.

After having taken the aseptic precautions as laid down above under diagnosis, try to pass a large sound, No. 20, French, which will probably not pass. Then pass in small whalebone filiforms, one after the other, side by side, until one passes the stricture point. Then attach a follower to this about the size of a No. 8 French sound, and slowly dilate the stricture. After passing a No. 8 and there is no marked bleeding, attach a No. 10 or 12, which if passed will relieve the condition to a great extent. Give the patient morphia, gr. ¼, and quinine, grs. x, to prevent the often met with urethral chill.

The patient should go to bed for a day or two, depending on the amount of shock produced. But as a rule he can be up if no exertion is indulged in. He should drink large quantities of water, and on the second day receive the second instrumentation, after aseptic precautions have been taken, when large sounds can be passed equally as easy as the first ones were. This should be kept up every other day, increasing the sounds each time until the normal size caliber of the urethra is reached, which will be at the end of two or three weeks. The symptoms will have cleared up, no doubt, and the patient think himself well, but it is of great importance for him to co-operate with the physician in the after-treatment.

After the first month sounds should be passed from No. 20 to 28, French, for about four months. Then once a month for six months, and about four times each year of the patient's life. When dilatation cannot be done, internal or external urethrotomy should be resorted to. In this class of strictures external urethrotomy is the operation of choice, but cannot be done in a certain class of cases, and, in fact, by some internal urethrotomy has been done with apparently no bad results. If the patient has some constitutional disease and cannot take a general anesthetic, or for any reason a general anesthetic is contraindicated, or if the patient is not able to withstand the shock of a perineal section, and especially if the confinement in bed following such an operation is unwise, one is justified in performing an internal urethrotomy on the deep urethra, regardless of the danger of hemorrhage and infiltration of urine in the surrounding parts, with all the various complications following.

In addition to the general preparation of a patient for an operation, the urine should be rendered non-irritating by the administration of salol or urotropin gr. vii three times a day for at least three days. If highly acid, give potassium bicarbonate to lessen acidity. Scrub up the external genitalia with soap and water, shave and follow with alcohol and bichloride of mercury. Irrigate the urethra well with 1-6000 potassium permanganate, followed by irrigation with sterile hot normal salt solution. Then, if possible, fill the bladder with sterile normal salt solution to render the urine less irritating, and to wash the cut surface after the operation.

Inject into the urethra as an anesthetic a 2 per cent. solution of cocaine. Pass in a filiform and thread the Otis urethrotome over it, having put the knife in the instrument previous to this. The stricture is dilated by turning the dial of the instrument to the desired size. Then the stricture is cut by pulling the knife outwards. The knife is pushed back, dilatation is increased and the knife drawn outwards again, to make sure the desired result has been accomplished. It is well then to pass a No. 28 French sound, irrigate out the urethra with sterile hot normal salt solution, which will remove the clots and arrest hemorrhage to a great extent.

Give the patient at once quinine grs. x and morphia gr. ¼. Order the patient to stay in bed for four days, as a rule, and drink an abundance of water and eat a light liquid diet.

At the end of 24 hours instrumentation should begin, and be kept up as described under the treatment of stricture in the deep urethra which is dilatable.

External urethrotomy should be employed—1st, on all undilatable strictures of the deep urethra; provided the patient is strong enough to withstand the shock of a general anesthetic and an operation. 2d. All traumatic strictures with infiltration of surrounding tissues with urine in the deep urethra. 3d. Impassable stricture complicated by retention.

External urethrotomy with filiform guide, over which is threaded a sound or catheter down to the stricture point, is the operation of choice. The operator by this means has no difficulty in finding the stricture by cutting down on the end of the sound parallel with the urethra, and then removing the sound and retracting the tissues, the filiform can be followed and the stricture incised without any difficulty. The external vesicle sphincter is dilated and a retention catheter put into the bladder and allowed to come out through the perineal wound.

Hemorrhage is controlled by artery clamps and hot normal salt solution. One in the after-treatment should look out for secondary hemorrhage, and treat it vigorously if it occurs. The patient should be put in the semi-recumbent position in bed and the bladder drain connected with a bottle to prevent the soiling of the bed linen. Good bladder drainage is of the greatest importance for the first four days, as it prevents the urine from coming in contact with the freshly-made wound until septic absorption is guarded against by formation of granulation tissue.

After the removal of the catheter, about the fourth or fifth day, the gentle passage of sounds through the entire urethra should be instituted. It is best to begin with as large a sound as will pass without any great discomfort to the patient, and gradually increased until the normal caliber is reached and the perineal drainage ceased with the complete healing of the wound.

The urethra and perineal wound should be irrigated before the sounds are passed with 1-6000 potassium permanganate, followed by sterile normal salt solution. It is well as a routine to give the patient morphia gr. ¼ and quinine grs. x after the operation to prevent a urethral chill. Bromides may be necessary to give the patient the proper amount of rest and sleep for the first few days, but should only be used in case of necessity. The patient will be able to be out of bed in the average number of cases in 10 days. To prevent recontraction and possibly a more extensive stricture, it is highly necessary to pass sound every other day for a month, once a week for three months, then once a month for six or eight months, then four times a year for the rest of the patient's life.

In conclusion, I wish to say that some strictures are so limited in extent that they may be excised and the several ends of the urethra united with catgut sutures, and that when this can be done it is an ideal method of treatment.

RADICAL CURE OF PAINFUL HALLUX VALGUS, WITH REPORT OF CASE.

By Nathan Winslow, M.D., 1901.

While my experience with painful hallux valgus is limited to the one case which I am about to report, the result obtained and the simplicity of the operative technic warrant its presentation to the readers of The Bulletin. Hallux valgus is that condition in which the axis of the great toe deviates outward from the norm in extreme cases as much as 90 degrees. The big toe, instead of projecting forward from the foot on an axis extending through the center of the great toe and the mid point of the heel, projects out-

ward across the toes. This condition arises from two factors at least—the wearing of too-short shoes and an abnormally long toe, the big toe extending from one-quarter to one-half an inch beyond the second toe, as a result of which cramping the axis of the large toe is made to extend outward. As there is an associated bursitis over the inner side of the metatarso-phalangeal joint, the condition is popularly designated bunion. Therefore, when used in this connection, bunion assumes a rather complicated aspect, for not only is there an inflammation of the bursa overlying the metatarso-phalangeal articulation, but also a partial dislocation of the toe, and in some instances exostoses on the head of the metatarsal bone, and at times a periostitis.

The wearing of shoes becomes unbearable, and walking with any degree of comfort is impossible. The pressure of shoes sets up cramp-like pains, which, in some cases, persists even after their removal. The joint is red and swollen and tender to pressure. No minor affection gives rise to greater inconvenience and discomfort to the patient, who is most frequently a woman.

Occasionally relief may be obtained by the use of various appliances or properly-shaped shoes, but most frequently relief can only be obtained by operation.

Many operative procedures have been devised for this trouble, among which may be mentioned the resection of the head of the metatarsal bone, arthrectomy of the joint, osteotomy of the metatarsal bone immediately behind the head, and the Mayo operation, resection of the head of the first metatarsal bone, with a restoral of the joint by the covering of the raw surface of the resected bone with a flap of synovial membrane obtained from the bursa. This operation gives immediate relief, and leaves the patient with a good, movable joint. In my case the result obtained was perfect.

REPORT OF CASE.

During the early part of March, 1911, Miss W. of Atlantic City, N. J., 38 years of age, consulted me about an extremely painful bunion of the right great toe, complicated by hallux valgus. The pain was so great that even after a very short walk she was compelled to remove her shoe. She had been suffering with the trouble for 15 years, and which, as time progressed, became gradually worse. The joint was red, swollen and painful to pressure. There was marked thickening about the joint. Deformity was marked, and the head of the first metatarsal bone could easily be palpated beneath the skin. The axis of the great toe had become deviated outward to about 60 degrees. I advised Mayo's radical operation, to which she consented.

Operation.—On Tuesday, March 14, the patient was anesthetized at the home of her father, in Baltimore, by Dr. W. H. Smith. A semi-circular incision was then made, beginning on the inner side of the foot near the plantar aspect of the base of the proximal phalangeal bone, and directed upward and swept over the head of the metatarsal bone. The skin flap thus outlined was dissected free from the underlying tissues, with its pedicle directed downward. The next step consisted in reflecting from the outer side of the head of the first metatarsal bone a flap with its base attached to the base of the proximal phalanx. This flap consisted mainly of fat, which was lined on its inner aspect by synovial membrane from the involved joint. The projecting head of the metatarsal bone was resected, and the fatty flap inserted between the raw surface of the resected bone and the base of the proximal phalanx, where is was held in place by a few sutures, thus giving a joint whose surface was lined throughout with synovial membrane. The skin flap was finally sutured with interrupted sutures of catgut. Drainage was provided for by inserting a few strands of silkworm-gut at the lower end of the incision. This was removed in two days, and the wound healed by first intention. The patient was out of bed on the third day, and by the tenth was walking about the house. In less than a month's time after the operation she had walked at one stretch more than three miles without any return of pain or discomfort.

The staff of the University Hospital for the ensuing year is as follows:

Medical Superintendent—Wm. J. Coleman, M.D.

Assistant Resident Surgeons—Drs. Joseph W. Hooper, Fred W. Rankin, Wm. A. Gracie, N. B. Steward, C. N. Devilbiss, A. C. McCall.

Assistant Resident Physicians—Drs. J. M. Blodgett, G. C. Coulbourn, R. C. Dodson.

Assistant Resident Gynecologists—Drs. H. B. Gantt, FitzR. Winslow.

Resident Pathologist—L. K. Walker, M.D.

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, AUGUST 15, 1911.

NEW REQUIREMENTS OF THE NEW YORK BOARD OF REGENTS.

The following circular from the New York Board of Regents and the reply from Dean R. Dorsey Coale are self-explanatory. For some time the writer has insisted that the die was cast, and that medical schools would soon be required to have at least five full-time, salaried instructors in the laboratories and scientific branches. It was not thought, however, that this requirement would become effective for several years. We had not read the handwriting on the wall aright. We are now face to face with an imperative order to supply six, not five, full-time, salaried instructors by October 1, 1912. The command admits of no argument; we must comply or lose our New York registry. We cannot afford to do this, and the order must be obeyed. Moreover, the various educational boards and associations are going to make the same ruling within two years. The gist of the matter is this: the medical school of the University of Maryland must get on an endowed basis or close its doors after a successful and honorable career of more than 100 years. Fellow-alumni, which do you prefer—to see your alma mater go out of existence, or to help us in the effort we are making to raise funds in order that she may survive?

State of New York,
Education Department,
Albany, July 14, 1911.

To the Deans of Medical Schools:

Allow me to call your attention to the following resolution adopted by the Board of Regents at a regular meeting held June 23, 1911:

"*Resolved*, That section 409 of chapter X of the Regents' Revised Rules be amended by adding thereto so that the first paragraph shall read as follows:

"Section 409, SCHOOLS OF MEDICINE. A school of medicine may be registered as maintaining a proper medical standard and as legally incorporated. It must have apparatus and equipment and resources of $50,000. It must by October 1, 1912, have at least six full-time, salaried instructors, giving their entire time to medical work; a graded course of four full years of college work in medicine, and must require for admission not less than the usual four years of academic or high-school preparation or its equivalent in addition to the preacademic or grammar-school studies."

Handbook No. 9, which contains the law, rules and information upon medicine, and issued by this department as one of the series of handbooks upon higher education, will be revised June, 1912, and will contain under the registered medical schools in each State only those institutions that will conform to the requirements of the above resolution by October 1, 1912.

I am calling your attention to this regulation of the Board of Regents thus early that your institution may have its proper recognition in the handbook.

Yours respectfully,
AUGUSTUS S. DOWNING,
First Assistant Commissioner of Education.

University of Maryland,
Faculty of Physic,
Baltimore, July 25, 1911.

Augustus S. Downing, LL.D.,
First Assistant Commissioner of Education,
Albany, N. Y.

Dear Dr. Downing—I have the honor to acknowledge the receipt of your circular-letter of July 14, containing the resolution recently adopted by the Board of Regents regarding the registration of schools of medicine.

As regards apparatus, equipment and resources, course of instruction offered and requirements for admission, this institution is, I believe, already very well up to the prescribed standard, and we hope, and confidently expect, that by the opening of the session of 1912-1913, the time stated in your letter, we will also be prepared to conform to the

requirements of the Board of Regents in the matter of the six full-time, salaried instructors.

With best personal respects and regards, I am,

Very truly yours,

R. Dorsey Coale,
Dean.

JOIN THE THRONG.

Owing to the absence of Professor Winslow during the past month, the additions to the fund for the endowment of the department of pathology have not been great, but several very acceptable subscriptions have been received. The sum total at present amounts to $7537, to which may be added the Faculty of Physic fund, already in the hands of the trustees, amounting to about $9000, raised chiefly through the efforts of Professor Cordell, the new and the old subscriptions thus aggregating the quite respectable sum of $16,500.

The subscriptions to August 1 are as follows:

Robinson bequest	$5000
Dr. Hugh Hampton Young, J. H. U.	100
Dr. S. J. Meltzer, LL.D., New York	10
Dr. Gideon Timberlake	25
Mr. H. P. Ohm	10
Dr. Samuel W. Moore, D.D.S.	25
Hospital Bulletin	5
Maryland Medical Journal	5
Miss C. M. Selfe	5
Prof. R. Dorsey Coale, Ph.D.	100
Dr. John J. R. Krozer, 1848	50
Dr. Eugene F. Cordell, 1868	10
Dr. Joseph T. Smith, 1872	10
Dr. W. J. Young, 1872	25
Dr. Thomas A. Ashby, 1873	100
Dr. David W. Bulluck, 1873	100
Dr. Robert Gerstell, 1873	5
Dr. Randolph Winslow, 1873	100
Dr. H. T. Harrison, 1874	5
Dr. Charles W. Mitchell, 1881	100
Dr. J. M. Hundley, 1882	250
Dr. Henry Chandlee, 1882	10
Dr. J. C. Perry, 1885	100
Dr. B. Merrill Hopkinson, 1885	25
Dr. H. C. Reamer, 1885	10
Dr. Frank Martin, 1886	100
Dr. C. W. McElfresh, 1889	100
Dr. Saint Clair Spruill, 1890	100
Dr. Rupert Blue, 1892	100
Dr. Harry Adler, 1895	100
Dr. Jose L. Hirsh, 1895	50
Dr. Joseph W. Holland, 1896	50
Dr. R. W. Sturgis, 1896	2
Dr. L. W. Armstrong, 1900	10
Dr. S. Demarco, 1900	50
Dr. M. S. Pearre, 1900	5
Dr. J. D. Reeder, 1901	50
Dr. Nathan Winslow, 1901	50
Dr. Arthur M. Shipley, 1902	250
Dr. H. C. Davis, 1902	10
Dr. H. L. Rudolf, 1902	25
Dr. Hugh Brent, 1903	25
Dr. G. C. Lockard, 1903	25
Dr. Geo. S. M. Kieffer, 1903	25
Dr. H. J. Maldeis, 1903	25
Dr. R. C. Metzel, 1904	10
Dr. Robert P. Bay, 1905	100
Dr. W. F. Sowers, 1906	25
Dr. Frank S. Lynn, 1907	25
Dr. T. H. Legg, 1907	5
Dr. E. H. Kloman, 1910	25
Thomas C. Basshor Company	10
	$7207
To August 1	330
	$7537

UNIVERSITY OF MARYLAND SHOULD APPEAL TO THE STATE FOR AID, AND SHOULD RECEIVE IT.

By the term University of Maryland is meant not a single department, but the school in its entirety, and not a particular school of the University. The various schools of the University of Maryland have for years furnished the State with her physicians, with her lawyers, with her pharmacists, with her dentists, and the Department of Arts and Sciences has given the preliminary college training to many of Maryland's most representative men, and this fact is recognized and warmly commended, yet the aid which the University has received from the State is comparatively little.

The foreign cry that Americans worship money, and have no reverence for things whose age alone should ensure them recognition, is not true of the University. The people of Maryland have a lasting love and veneration for the old school which has served their fathers before them, and would sacrifice heavily rather than see

the University lose in prestige or suffer financial reverses, and the one reason that more financial aid is not accorded the University from the people of the State is that its claims have not been presented to them in terms sufficiently emphatic. There are men who have worked untiringly in the service of the University, and our love and esteem for them is great, yet this service and the upbuilding of its departments is a work too stupendous for any one man or for any ten men to accomplish. It is a work that its teachers, its students, its alumni and its admirers and beneficiaries alike must unite in, and with all their strength. Its claims must be made urgent, its needs made apparent. There is a settled conviction on the part of the public of Maryland that the University of Maryland is a rich institution, else its doors had not been kept at their disposal these many years. The tales of sacrifice and the stories of personal endeavor so intimate to us are not and have never been public property, owing to a spirit of pride, false, it is true, but nevertheless noble. We can go on as we are now doing, and year after year individuals must pay the price of our pride, while, on the other hand, an earnest appeal with a truthful statement, backed up by proofs, of the exact financial needs of the University, presented publicly and forced upon the knowledge of Maryland legislators by worthy representatives of the school, cannot but secure the desired end. Unless the University of Maryland receives adequate support from the State of Maryland it is not to be hoped that the efficient and distinguished service she has rendered this State can be unabatedly continued.

Today, while the University is doing good work, seems the opportune moment for pressing her claims and for securing the aid necessary for the continuance of that good work. Claims made upon private individuals for support, long continued, become burdens to the donor, and alms to the recipient; claims made upon public bodies for support, periodically, become rights, the withdrawal of which is a public injustice and is treated accordingly. To secure State aid for the University as a permanent factor in its welfare will require the strongest presentation of its needs before the coming Legislature. Once the fact is forced upon it that the University is really needy, the battle is won, and future appropriations will be merely a matter of form, but the start must be made. Other schools, with vastly greater resources than those of the University, do not hesitate to press their claims, and are usually the gainers thereby. We would not ask that the University receive immoderate aid from the State; we would not have her lose her personal independence; but we consider that the University of Maryland has done far more for the State of Maryland than the State of Maryland has ever done for the University, and any recognition accorded her, no matter how great, is merely a portion of her just due. The work of a select few of our alumni alone has been sufficiently distinguished to merit such regard, independent of the combined work of our less celebrated alumni. A university capable of producing a Carroll, a Carter, a Blue, a Councilman, is surely not derelict in its duty to the public.

The public is with us, but they do not know our need. So boldly have we faced conditions, so excellent a front have we presented, that a tale of our need would be unbelieved unless presented by a representative body of our men and in such straight, direct and forceful language that there can be no misunderstanding. We would suggest the securing of such aid as a field of vast possibilities for the work of the Advisory Alumni Council, and we would plead for the combined support of each and every person interested in the old University, so that we can present in telling fashion our needs to the General Assembly of the State of Maryland on the occasion of its next meeting.

ITEMS

Dr. Walter Colwell Gordon, class of 1907, of 1250 Cranston street, Providence, R. I., writes: "THE BULLETIN is always a welcome visitor, as it is the only means I have of keeping track of classmates and progress at the University."

Dr. Charles W. Famous, class of 1901, of Street, Md., is prominently mentioned as a Democratic nominee for the House of Delegates from Harford county, Maryland.

Dr. Albert Hynson Carroll, class of 1907, writes from Wood's Hole, Mass., where he is spending the summer: "I received your letter, and should have answered it weeks ago. My excuse is that when Dr. Hemmeter don't require me, I am busy at my work in the Marine Biological Laboratory.

Plenty of work all day. Everyone works here from early morning to late at night. They fairly eat work, they love it so. It is a very charming place, and affords most excellent facilities for research work."

Dr. Calvin C. Peters of Princeton, W. Va. (class of 1906) has been recently appointed president of the Board of Health and Physician to the County Infirmary for Mercer county, West Virginia, at a salary of $1800 per year.

The publishers of the BULLETIN are very desirous of securing the following copies of the BULLETIN: July, 1905 (Vol. 1, No. 5), January, 1907 (Vol. 2, No. 11), and March, 1908 (Vol. 4, No. 1). We would be more than glad if some of our readers could send us these missing issues.

Dr. Allen Kerr Bond, class of 1882, will reside in Forest Park in future.

Dr. Cary Breckinridge Gamble, class of 1887, of 26 W. Biddle street, is spending several months in Europe.

The members of the Baltimore County Medical Association were the guests of Dr. G. Carville McCormick, class of 1890, and Dr. Frank Eldred at a crab feast at Penwood Grove, Baltimore county, July 19.

Dr. Horace M. Simmons, class of 1881, will spend the latter part of August at Rangeley Lakes, Maine.

Dr. Henry J. Berkeley, class of 1881, is summering at Magnolia, Mass.

Dr. Charles O'Donovan, class of 1881, is spending the summer at his summer home, Wicklow farm, Phoenix, Md.

Dr. Joshua Royston Green, class of 1899, of Towson, Md., has been spending some time at Cape May.

Dr. Robert L. Mitchell, class of 1905, who we reported ill some time ago, has entirely recovered, and quite recently spent some time on a trip with Dr. George M. Settle of Baltimore on the sailing yacht Grace.

Dr. Thomas Chew Worthington, class of 1876, is spending the summer in Massachusetts, as is his custom.

Dr. Ephriam Hopkins, class of 1859, is located at Darlington, Md. Dr. Hopkins has been in practice here over 50 years, and has won the admiration of all by his devotion to his work. He is a member of the Society of Friends, and includes among his patients almost all the Friends in that vicinity.

Dr. Walter B. Kirk, class of 1893, is also located at Darlington, Md. He is vaccine physician for the fifth district of Harford county, and sanitary officer for the entire county.

Dr. Frank P. Smithson, class of 1880, is located at Forest Hill, Harford county, Md. He was for many years vaccine physician for Harford county.

Dr. Randolph Winslow, class of 1873, has returned to his home in Baltimore after a trip to the Pacific Coast, the Yellowstone Park and the Grand Canon of the Colorado.

A committee of the Baltimore County Medical Society is sending circulars to members asking subscriptions to purchase a portrait of Dr. James H. Jarrett, class of 1852. The portrait will cost about $250, and is to be hung in the hall of the Medical and Chirurgical Faculty of Maryland.

Dr. John Evans Mackall, class of 1908, who was assistant surgeon at the Atlantic Coast Line Railroad's hospital at Rocky Mount, N. C., has resigned and returned to his home at Elkton, Md.

A letter from Dr. J. C. Perry, class of 1885, of Ancon, Panama, says in part:

"I am enclosing check in amount $100 for the endowment fund, and our alma mater has my very best wish for success and a continuation of the good work it has done in the past.

"We (the class of 1885) are so scattered that a class reunion seems impossible, but I know of no event that would cause me more pleasure."

Dr. Henry Chandlee, class of 1882, will spend August at his camp in the Thousand Islands, Canada.

Dr. B. Merrill Hopkinson, class of 1885, who has for the past 21 years been choir director and soloist at Brown Memorial Presbyterian Church, has resigned to accept a similar position at St. Michael and All Angels' Protestant Episcopal Church.

Dr. Arthur E. Cannon, class of 1909, of 821 North Fremont avenue, Baltimore, Md., will make his future home in Spartanburg, S. C.

Bishop Luther B. Wilson of Philadelphia, a graduate of the medical department of the University of Maryland, class of 1877, and son of Dr. Henry M. Wilson, class of 1850, of 1006 Madison avenue, Baltimore, is ill with an attack of African fever and heart trouble at the Thackeray Infirmary, London, England. The latest reports say that he is now well on the road to recovery.

Bishop Wilson was stricken by the fever while in Beria, Portuguese East Africa, in the early part of June. On June 16 his heart became affected, and for 10 days his life was despaired of. However, he slowly began to improve, and as soon as his condition was considered strong enough to stand the trip he was moved to England, arriving in London on Saturday, July 15. Since arriving in London his convalescence has been rapid, and at the present time it is expected that he will return to his home, in Philadelphia, by September.

Before he was stricken Bishop Wilson had spent about seven months in Africa. During that time he had traveled over a great part of the continent.

Even before he was made a bishop, Dr. Wilson was well known in the Methodist Episcopal churches of this city. Bishop Wilson studied medicine at the University of Maryland after graduating from Dickinson College. He graduated and then practiced medicine for one year before he entered the ministry.

His first appointment was under Rev. Watson Case of the Hancock circuit. He was next pastor at Calverton; then at Clipper Church, Woodberry; Jackson Square and Strawbridge churches. He served two terms as one of the presiding elders of the conference.

However, one entire term intervened between his first and second incumbency. His first term he was presiding elder of the Washington district and the second of the West Baltimore district. During the interim between his terms he served as pastor of Foundry Church, in Washington. He presided at the conference recently held at Harlem Avenue Church.

He was made a bishop at the conference in Los Angeles in 1904. At first he went to Tennessee, where he served for a time, when he was transferred to Philadelphia, which is still his headquarters, his trip to Africa being only temporary work.

Bishop Wilson has always been deeply interested in the work of foreign missions. As far back as 1906, just two years after his appointment, he was mentioned in the filling of a vacancy as one of the missionary bishops in Africa, and a short time later there was talk of the church sending him to China. However, it was not until last fall that he really was called upon for some work in foreign fields.

His wife was a Miss Turner.

We sincerely hope that in our next issue we may be able to report that Dr. Wilson is fully restored to health.

Among the candidates who successfully passed the Maryland State Board examination were the following:

Burt Jacob Aster, Walter Compton Bacon, Feuhler Shoup Boyer, William Luther Beverly, Henry Dickinson Causey, Herbert Augustus Codington, Louis Harriman Douglass, Charles L. Dries, James Joseph Edelen, Abraham Lewis Hornstein, Kenneth B. Jones, Charles Hutchinson Keesor, Charles R. Law, Jr., Isaac Michel Macks, George Yellot Massenburg, Walter Saulsbury Niblett, Elijah Emera Nichols, Vernon Llewellyn Oler, John Ostro, James Earle Quigley, Stanley H. Rynkiewicz, Charles Louis Schmidt, Joseph Stomel, Ralph Leland Taylor, Grafton Dent Townshend, Albert G. Webster, Richard Lloyd Williams, all of the class of 1911, and R. Gerald Willse, Charles A. Neafie and George E. Bennett, class of 1909, and William V. Parramore and Nathaniel Garb, class of 1910.

Dr. George Walter, class of 1910, formerly of Baltimore, has opened an office at 131 West Adams street, Jacksonville, Fla.

The clinical assistants at the University Hospital for the coming year are:

R. E. Abell, South Carolina.
R. A. Allgood, South Carolina.
R. G. Allison, South Carolina.
G. C. Battle, North Carolina.
H. A. Bishop, District of Columbia.
R. A. Bonner, Jr., Maryland.
S. E. Buchanan, North Carolina
W. T. Chipman, Delaware.
W. R. Claytor, South Carolina.
J. D. Darby, Maryland.
R. H. Dean, Jr., Florida.
H. Deibel, Maryland.
J. A. Duggan, Georgia.
I. Fajardo, Cuba.
W. E. Gallion, Jr., Maryland.
D. O. George, Maryland.
J. E. Hair, Jr., South Carolina.
H. Irwin, North Carolina.
E. S. Johnson, Maryland.
J. K. Johnston, Florida.
G. H. Lebret, New Jersey.
M. L. Lichtenberg, Maryland.
A. G. Martin, Cuba.
W. Michel, Maryland.
Benj. Newhouse, Maryland.
R. B. Patrick, South Carolina.
C. W. Rauschenbach, Maryland.
W. M. Scott, Georgia.
J. D. Sharp, Indiana.
D. Silberman, Maryland.
G. A. Stem, Maryland.
J. H. Traband, Maryland.
L. J. Vega, Cuba.
M. Vinciguerra, New Jersey.
H. R. Wiener, Pennsylvania.

Dr. Rufus Franklin, class of 1907, of Graymount, Ga., was a recent visitor to Baltimore.

Dr. Charles Franklin Strosnider, class of 1909, of Clinton, N. C., writes: "I am now in charge of 10 free hookworm dispensaries in Sampson county, under the auspices of the State and county. I have a microscopist; we make microscopical examinations and administer the treatment free. The dispensaries are very popular; am finding about 70 per cent. of all ages positive. Will run the dispensaries about six weeks in this county."

A letter from Dr. Charles Wesley Roberts, class of 1906, of Douglas, Ga., says: "This fall I expect to pay a visit to the old University, and I trust I may have the pleasure of renewing my acquaintance with a host of the good friends I once claimed at the University as teachers or graduates therefrom." We will all be very glad to welcome Dr. Roberts.

Dr. FitzRandolph Winslow, class of 1905, has left on a trip to Jamaica and the West Indies. In a letter from the Hotel Camaguey, Camaguey, Cuba, he writes: "I arrived at a little Cuban seaport several hours after the train for Camaguey had pulled out, so was compelled to stay in limbo for 24 hours, as nothing else was going my way until today at 7.50 A. M., which arrived here about 3.30 P. M. The train stopped frequently at mere shacks, but I felt as though it was running rather fast. As this is a rather high altitude, I am not being bothered by the heat. This is the rainy season, but one is not bothered by it. Like most things that people talk about, I have heard all sorts of conflicting statements about places and customs, and generally find out that only a few knew what they were talking about. Everybody seems agreed on one point, however, and that is, that Santiago de Cuba is a mighty hot place, but I have decided to go there and take the boat for Jamaica from that point."

Dr. Coale is in receipt of the following kind and interesting letter from Dr. A. W. Giampietro, class of 1907:

"Dear Dr. Coale.—It is my pleasure to enclose herewith a carbon copy of a preliminary investigation concerning the rôle that the bacillus coli plays in vegetable pathology. This paper will be published through the Department of Agriculture, but I wish you would also publish it in your Hospital Bulletin, as my first scientific contribution to my alma mater.

"I am now conducting a comparative study with bacillus coli, thyphosus and mesentericus vulg. as to their relation to plant diseases, and as soon as the investigation is completed I will try to come to the University and have a conference with the alumni and professors about this very important branch of pathology.

"In view of the fact that I am indebted to the University of Maryland for many opportunities

offered to me when a student, I feel an obligation to give her full honor and credit for what she is as a reproach to those who have tried to degrade her in every respect.

"Since the few and only preliminary works of Laurent, my investigations are the first to appear on this subject, and I believe will interest every bacteriologist.

"Hoping you will accept my contribution as a token of appreciation of the University and of yourself, I beg to remain,

"Sincerely yours,

"A. W. GIAMPIETRO."

Dr. Giampietro's article appears elsewhere in THE BULLETIN.

Dr. Edward J. Bernstein, class of 1887, of 810 Kalamazoo National Bank Building, Kalamazoo, Mich., writes that "we get along merrily and enjoy life." Dr. Bernstein limits his practice to diseases of the eye, ear, nose and throat.

Dr. Bennett F. Bussey, class of 1884, of Texas, Md., was a recent visitor to the University Hospital.

Amongst our Alumni located in North Carolina are the following:

MATTHEWS.

Harry Q. Alexander, class of 1898.

MAXTON.

Arthur Baxtom Croom, class of 1905.
H. Wise McNatt, class of 1881.

MILLINGPORT.

Daniel P. Whitley, class of 1889.

MONCURE.

W. J. Strickland, class of 1890.

MONROE.

Samuel Amos Stevens, class of 1900.
Henry Dixon Stewart, class of 1898.

MOORESVILLE.

Andrew E. Bell, class of 1897.

MOREHEAD CITY.

William E. Headen, class of 1891.

MORGANTON.

Charles E. Ross, class of 1889.

MORVEN.

Dunlap Thompson, class of 1901.

MOUNT OLIVE.

William C. Steele, class of 1891.

MOUNT PISGAH.

Gurley D. Moose, class of 1907.

NASHVILLE.

James P. Battle, class of 1888.
J. T. Strickland, class of 1890.

NEWBERN.

Robert Duval Jones, class of 1896.

NEWPORT.

Oswald Ottmar Kafer, class of 1905.

NEWTON.

James R. Campbell, class of 1876.
William H. Everhart, class of 1903.

NORWOOD.

Thomas A. Hathcock, class of 1893.

OAK RIDGE.

John Robert Pattison, class of 1902.

Of the class of 1874 we are able to locate the following:

Howard E. Ames, U. S. N.
Joseph S. Baldwin, Freeland, Md.
R. C. Buck, Orlean, Va.
M. S. Butler, Hedgesville, W. Va.
D. L. Cheatham, Sandersville, Ga.
A. P. Dodge, Hickok block, Oneida, N. Y.
Elisha C. Etchison, Gaithersburg, Md.
Rezin Warfield Hall, Moundsville, W. Va.
Henry T. Harrison, Loch Raven, Md.
J. Rufus Humphrey, Ely, Minn.
Col. L. M. Maus, Federal Building, Chicago, Ill.
C. C. McDowell, 1521 West Fayette street, Baltimore, Md.
E. S. Miles, Upper Fairmont, Md.
Eldridge C. Price, 1012 Madison avenue, Baltimore, Md.
O. H. W. Ragan, Hagerstown, Md.
T. E. Sears, 658 West Franklin street, Baltimore, Md.
John T. Shepherd, Loveman Building, Chattanooga, Tenn.

At the recent annual meeting of the Medical and Chirurgical Faculty of Maryland the following alumni were elected to official positions: Dr. John L. Riley, class of 1905, of Pocomoke City, and Dr. Daniel E. Stone, class of 1864, of Mount Pleasant, Md., vice-presidents; Dr. James W.

Humrickhouse, class of 1873, of Hagerstown, Md., trustee; Dr. Charles O'Donovan, class of 1881; Dr. Lewis C. Carrico, class of 1885, of Bryantown, Md.; Dr. James E. Deets, class of 1882, of Clarksburg, Md., and Dr. Harry B. Gantt, class of 1880, of Millersville, Md., councilors; Dr. G. Lane Taneyhill, class of 1865, of Baltimore, delegate to the American Medical Association, and Dr. James H. Carroll, class of 1893, of Baltimore, alternate.

MARRIAGES

Dr. Lewis Morris, class of 1890, surgeon in the United States Navy, was married on August 1, 1911, to Mrs. Ella Bingham Duffy. The ceremony was performed by Rev. William Courtney, assisted by Rev. Matthew G. Gleason, chaplain of the Brooklyn Navy-yard. After a motoring trip through New England the couple will reside in New York.

DEATHS

Dr. Frederick Birdseye Baker, class of 1888, died of apoplexy at his home in East Norwalk on April 17, 1911, aged 55 years. He is survived by a wife, a daughter and a son. Dr. Baker was born in Warehouse Point, Connecticut, on May 9, 1855. He was a member of the Masonic Order, of the Knob Club, the South Norwalk Club, the East Norwalk Yacht Club, the Mayflower Hook and Ladder Company, the Norwalk Medical Association, and was a director of the South Norwalk Savings Bank. His sudden demise was a great shock not only to his family, but to the community in which he lived. He was loved and is mourned by many.

Dr. George W. Truitt, class of 1875, died at his home in Roland Park, Md., July 11, 1911, at 6 P. M. of paralysis after an illness of two years.

Dr. Truitt was the son of the late Rufus K. Truitt, who was a druggist in Salisbury, Md. Dr. Truitt obtained his early training in the public schools of Salisbury and came to Baltimore when a young man. He entered the medical department of the University of Maryland, from which he was graduated in 1875. He went to Salisbury and practiced medicine for 12 years. He was a member of the Legislature from Wicomico county in 1890.

In 1897 Dr. Truitt came to Baltimore and bought a pharmacy in Roland Park, which he conducted until his death. In 1900 he was elected a member of the Legislature from Baltimore county.

He was deputy insurance commissioner of Maryland for 12 years.

He was buried in Druid Ridge Cemetery. Dr. Truitt is survived by a widow, who was Miss Helen D. Wolf of Baltimore.

LABORATORY REPORT OF THE UNIVERSITY HOSPITAL.

MONTH OF JULY.

Blood Examinations.

Leucocyte Counts	169	
Erythrocyte Counts	15	
Differential Leucocyte Counts	11	
Hemoglobin Determinations	62	
Smears for Malarial Parasites	10	
Blood Cultures	4	
Wasserman Tests	24	
Widal Tests	48	
Blood Pictures	4	
		347

Urine Examinations.

Routine Urinalysis (chemical and microscopic)	360	
		360

Miscellaneous.

Gastric Contents (chemical and microscopic)	11	
Feces (microscopic, etc.)	14	
Sputum Examinations	12	
Bacteriological Cultures and Smears (from operative cases)	18	
Bacteriological Smears (non-operative cases)	6	
Spinal Fluid Examinations	1	
Pleural Fluid Examinations	3	
Anti-typhoid Vaccines (kindness of Drs. Stoner and Hachtel)	90	
Autopsies	2	
Section of Tissue for Microscopic Examination	14	
		171
Total		878

DR. J. L. HIRSH,
DR. H. J. MALDEIS,
DR. L. K. WALKER,
W. M. SCOTT,
E. S. JOHNSON.

THE HOSPITAL BULLETIN

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A HURRIED TOUR THROUGH EUROPE.

By T. A. Ashby, M.D.

The dreams of many years were fully realized when, on the morning of July 14, I landed in old England after a safe and pleasant passage across the Atlantic. The good steamer in which I had embarked anchored in the splendid harbor of Liverpool at 1 o'clock A. M. We were detained on board until the health officers and custom-house inspectors gave us permission to go ashore. At 6 o'clock in the morning we climbed down the side of the steamer on a long ladder to the deck of a tug, which conveyed us to the shore landing. This gave us a splendid opportunity to see the great harbor of Liverpool with miles of docks and hundreds of vessels of every description engaged in the commerce of that city, which is said to be the third in size and tonnage of any city in the world, London ranking first and Hamburg second.

After landing we made search for the best hotel we could find, and for the first time since leaving home enjoyed a real breakfast. After breakfast my friend, Mr. W. C. Page, president of the Calvert Bank, who was my constant companion during my trip abroad, and I took a cab and for several hours were driven through the business and residential sections, the public parks and such places of interest as were within our reach. We found much to admire in the solid and beautiful city of Liverpool, with its population of some 900,000 people, with its splendid public and private buildings, monuments and institutions, all showing greatness of accumulated wealth durthe centuries since the city had had its birth. We saw enough of Liverpool to impress us with the fact that cities of wealth and of solid growth, of substantial and stately buildings, of splendid streets and noble parks are the products of years and even centuries of earnest labor and uninterrupted progress, of sound civic government and a high-spirited citizenship. Great cities, like great oaks, must grow slowly to secure a hard fibre and long life. The large centers of population we visited during our travel through Europe have been centuries in reaching their present size and importance. This slow process of growth, contrasted with the rapid way American cities have sprung up, explains the difference in the architecture, public and private buildings, streets, water supplies, sewage and illumination observed in European cities and those found this side of the Atlantic. It has taken centuries in Europe to construct the splendid architectural monuments which are the chief ornaments of European cities. Many of the great buildings, churches and galleries of art had their foundations laid long before Columbus crossed the Atlantic. It is the element of time which has given reliability and endurance to the civilization of the Old World. Apart from this, with the vigor and rapid growth of American ways and methods we are fast approaching, and will in no distant day go beyond, all European models.

After a thorough view of Liverpool we took the Midland Railroad for London, which may be reached in less than five hours, the distance being over 200 miles. The ride through rural England was a most enjoyable one. The railway service was by far the best we had in Europe. The train carried us through a number of large cities and many villages, but stops were made at few places. The country was most picturesque and beautiful in many places. As we passed by the Peaks of Derby the cars carried us through the most perfect scenery of mountain and valley, in which every acre of land had been cleared of timber and was covered with a velvety green pasture, giving

support to herds of stock. These highly cultivated mountain lands show to what high art farming has been carried in England. Every acre of ground has been utilized by man, and must pay tribute to human industry. The harvest was just ripe as the train bore us through fields of oats, golden wheat and meadow lands filled with laborers gathering in their crops. The more level farm lands of Leichestershire were less evident in cultivation, but herds of splendid cattle and flocks of the Southdown sheep were browsing in pastures which would bring joy to the American farmer. There is so little waste land in England that intensive farming is practiced in a skillful way. I saw no corn in cultivation in any portion of Europe through which I traveled. Wheat, oats, hay, potatoes, hops and barley are the staples. In England and Holland I saw large and beautiful herds of cattle and some superb horses.

We reached London at 5 P. M. July 14, and were driven in a taxi to the Inns of Court Hotel in the very heart of old London, just across the street from Lincoln Inns Fields. We found most pleasant accommodations, and from the close proximity of the hotel to noted London objects of interest we were able to visit the scenes of historic interest close by made famous by the pen of Dickens and by Boswell in his "Life of Johnson." The Old Curiosity Shop still stands, a lonely relic of the past, within two blocks of the hotel. Fleet street, now a great business center, was not far away from the Old Curiosity Shop. As I recalled the famous men of literature—Sam Johnson, Oliver Goldsmith, David Garrick, Sir Joshua Reynolds, Edmund Burke and others whose lives were so intimately associated with this section of London—I could not escape the conviction that time works havoc with the monuments of man, but his glory is imperishable if once faithfully recorded in the history of his generation.

After a bath and good dinner Mr. Page and I left the hotel for a stroll through London. As the dusk in England does not deepen until after 9 o'clock, we had a good hour of daylight for sightseeing, which we used until our feet were too tired for further walking. We then took a taxi and, giving instructions to the chauffeur where we desired to go, for some two hours we were whirled through the streets of London at a pace that was almost too fast for solid comfort. We must have covered some 35 to 40 miles, for we visited St. Paul's, The Tower, crossed Tower Bridge, returned by London Bridge, coursed along the embankment to House of Parliament next to Westminster Abbey, to Buckingham Palace, the city residence of George V; through St. James,' Regents' and Hyde Parks, and then through much of the business and residential sections of the city. London is beautifully illuminated with incandescent lights, and as traffic is light at night a taxi is able to cover long distances with great ease. The streets of London are the best paved I have ever seen. The taxi service cannot be excelled, as it is well-nigh perfect. We rode for some two hours, and when we came to pay for the service, the meter registered eight shillings (about $2 in American money). We gave the chauffeur two shillings as a tip, which he acknowledged with so much politeness that we believed we had given more than the accustomed allowance. This ride after night gave a most charming impression of London. When we retired to our rooms we were worn out with the fatigue of the day. Having landed in Liverpool at 6 o'clock in the morning, by 11 o'clock P. M. of the same day we had traveled many miles by cab, rail and taxi; had seen many new and interesting objects, and had registered many impressions which will linger until our brains cease to function. I had smoked so many cigars during the day, and my brain was so charged with the experiences of my first visit to England, that it was long after midnight before I fell into a deep sleep. At 8 o'clock the following morning I was up and dressed as fresh in body and mind as a boy taking his first outing. After a good English breakfast we decided to see on foot the banking section of London, and to visit, especially, Brown, Shipley & Co. and Thomas Cook & Sons, with whom we had letters of credit, and from the latter of whom we were to secure tickets for travel through Europe. I cannot say too much for the courtesy and wonderful system of this latter house. They have agents in every important city in Europe, and book the tourist over routes which he could scarcely make without their assistance.

Our business was finished by 10 o'clock, when we went to Westminster Abbey and Parliament House for closer inspection than we had had the evening before. My visit to both of these places was rather disappointing. I had expected to see in the interior of these buildings more imposing sights and more interesting objects than those

presented. The Abbey in the interior is much smaller than its outward appearance would indicate. At the time of my visit it was crowded with the stands and chairs used during the recent coronation. Many of the monuments to England's noted dead were hidden from view. We could only see those high up on the walls or under the floor over which we walked. It was difficult to realize that we stood in the presence of all that remains of England's buried rulers, statesmen, soldiers, poets, scientists, scholars and men of renown now sleeping beneath the lofty roof of the Abbey. I thought to myself, What does it profit these dead to sleep in this consecrated place? Are they any better off than millions who lie buried under many a forgotten mould of clay? Yet one must realize that men have endured every act of human toil, have braved all danger, have sacrificed blood and treasure, have lived in the jungle with savages and beasts of prey or in climates and situations unsuited to health of body and mind all for the distinction and glory of a long sleep in the dark house and gloomy halls of this old Pantheon.

The only satisfaction I had in my visit to the Abbey was a close view of the chair in which the kings of England have been seated during coronation and the stone of Schone resting under the chair which for over 1200 years has been present at these exercises.

The House of Parliament on the Thames embankment is a stately structure. Its interior is beautifully embellished with paintings and statuary representing many of England's kings, queens, princes and nobles, as also her greatest statesmen, orators and soldiers. The Halls of Parliament, both Lords and Common, are contracted and uncomfortable places for conducting business. As contrasted with our own Capitol at Washington, the comparison is all in favor of our country.

I do not hesitate to say that the Hall at Annapolis in which the House of Delegates meets is a more elegant and comfortable place for the conduct of legislation than either of the Halls of Parliament.

Buckingham Palace, the city residence of the King, is an enormous building, covering much ground and surrounded by beautiful gardens and parks. Its exterior is dark and dingy, and could be greatly improved by a coat of paint. As I did not enjoy the privilege of seeing the interior of the palace, I must imagine it is very beautiful to make up for the homeliness of its exterior, which looks more like a large hospital or reformatory institution than the home of a king. The beautiful flowers around the palace, the artistic way in which they are cultivated with variations of color and the appeal which they make to one's refined sense of taste are in striking contrast with the building which they surround.

In the afternoon and evening we took our third tour over London in a taxi. During this trip we had the agreeable society of several lady friends from America visiting London. We rode for many miles and saw a few of the places we had visited before and many new objects of interest. I began to feel that I knew London perfectly well, yet it is an enormous place, covering miles of territory, with its 6,000,000 or more of people.

Sunday is a day of rest in London. We observed the morning by going to religious exercises held in St. Paul's. This grand and massive temple, erected to the worship of God over 200 years ago, still stands as a monument to the genius of its architect, Sir Christopher Wren. Though stained and worn by the uses of time, St. Paul's is, to my mind, the most impressive building in London. There are others larger and more costly, but none which create such feelings of respect and veneration for all that is noble in art or beneficial in its services to man. The religious services, conducted by the clergy of the Church of England, were so pure and elevating that the spirit of reverence must steal its way into the hardest soul. The music rendered by the organ and chorister boys, the chanting and responses rang through the great halls and dome of the building in sweetest notes I have ever heard. There was a dignity and refinement in the service that made my soul feel that I was in the real presence of those spirits who are said to make music around the throne of the Great King of Kings.

St. Paul's is a wonderful house of worship, and a great monument to England's religious life. Such temples, made with human hands, are splendid types of that House not made with hands eternal in the heavens. The glory of the earthly is a symbol of the glory of the heavenly.

As I stood on the broad pavement in front of St. Paul's and looked at her immense walls, magnificent columns and lofty dome reaching far up toward the heavens, my mind involuntarily recalled the prophetic words of Macaulay in his comments on the Church of Rome, where he says:

"She may still exist in undiminished vigor when some traveler from New Zealand shall, in the midst of a vast solitude, take his stand on a broken arch of London Bridge to sketch the ruins of St. Paul's." I thought whilst such a prophecy might some far distant day be fulfilled, as all material structures are perishable, that the spiritual truths for which St. Paul's now stands are perhaps as imperishable as the human soul, and for all time will hold out to the heart of man the hope of glory and promise of eternal life. I turned away from St. Paul's feeling that our best interests in this life and our dearest hopes of a life beyond are greatly ennobled by these magnificent temples constructed by human hands to Divine service.

Monday was given exclusively to the British Museum and hospitals of London. As soon as the doors of the museum were thrown open to visitors I entered this great storehouse of art, literature and ancient lore. The building, large and imposing, covers many thousand square feet of space in the very heart of London. Its various rooms, halls and galleries are loaded with collections covering almost every department of human learning, coming down from prehistoric times to the present day. In its different rooms can be found the relics of every ancient civilization arranged and classified so that the student can gather an enormous amount of information on almost every subject. I was chiefly interested in the archaeological department, assigned to the Grecian and Roman collections, and gave the greater portion of my time to an examination of the classic works of sculpture and architecture brought from Greece and Italy. Marble busts and statues of Grecian characters and of Roman kings and emperors are wonderfully well preserved, and present life-like portraits of the distinguished men they represent. One seems to stand in the very presence of the Caesars, Julius, Augustus, Tiberius, Nero and many others; the Antonines, Severus, Caracalla—men who either ennobled or degraded Rome, now chisled in marble with noble features or mean and sensuous expressions.

The collection of Grecian architecture is very artistically arranged. Along the walls of the room are remnants of the frieze from the Parthenon at Athens, brought to England some years ago by Lord Elgin. This frieze, representing in sculptured marble the Panatheanic festival in very low relief, is 3 feet 4 inches in height and 520 feet in length. Many of the slabs of the frieze have been broken and lost, but have been restored in plaster of paris, which is placed below the original and gives a perfect representation of the highest attic art. The Partheon and the Acropolis have been restored in miniature and stand out in the hall of the museum as an almost perfect type of Athenian architecture. The Egyptian collection is of equal interest to the antiquarian. It is full of mummies and mummy cases, and of remnants from ancient Egyptian temples.

I was much interested in the collection of ancient and even more recent manuscripts, letters and autographs, so well preserved as to be legible. Letters in the handwriting of many of the kings and queens of England and of numerous men of distinction, from Chaucer down to the present generation, are open to inspection under glass covers. One could spend weeks in the museum with equal interest and profit. My visit was a very hurried one, but I brought away with me very vivid impressions and much food for thought and meditation.

I next made a hurried visit to Middlesex Hospital, in the center of London, near Oxford Circus, and only a few blocks from Regent's Park. This institution was founded in August, 1745, and from small beginnings has grown to its present size, its buildings now covering several acres of ground with a capacity of 340 beds. The number of in-patients treated during the year 1910 was 5434, and 54,240 out-patients. The total expenditures of the hospital were about $175,000, with receipts slightly less. These figures are given to show the size of the institution. Through the courtesy of the resident officers I was conducted through the hospital by the superintendent of nurses. I had a good opportunity to see the character of the buildings and the conduct of the work. At the time of my visit, midday, there were no operations going on. There was much activity about the buildings, and extensive repairs were being made in some of the wards. I have few comments to make, as I saw very little to condemn or to praise. The buildings and grounds were in good condition, and the hospital seemed to be doing its work along modern lines and in that conservative way characteristic of English methods. The Middlesex Hospital Medical School, a school of the University of London, is conducted in connection with the hospital. It is fully equip-

ped for the theoretical and practical teaching of all the subjects connected with the medical curriculum. Every student before entering a medical school in England or registering his name at the General Medical Council must produce evidence of having passed a preliminary examination in such subjects of general education as are accepted by the various examining bodies to whose examinations he intends to proceed, and must have attained the age of 16 years.

The Middlesex Hospital Medical School has a large faculty and corps of teachers and an annual attendance of some 300 students. The system of instruction is largely clinical and laboratory. There is little, if any, didactic teaching. The fees for instruction are about the same as are charged by the best schools in this country. There are a number of students' clubs and an athletic ground of some eight acres within easy access at Park Royal, where athletic exercises are open at all seasons of the year. A large number of valuable scholarships and prizes are awarded annually.

My next visit was made to the London Hospital and Medical School, University of London, which is located in East London, on Whitechapel and Mile End roads, a densely crowded section of the city. I spent some three hours in this institution. Through the courtesy of the Warden I was given permission to go through the medical college buildings and through the hospital adjacent thereto. The college buildings are large and handsome structures, admirably adapted to the work of instruction. I was introduced to Dr. W. Bullock, professor of bacteriology and pathological histology, who courteously gave me an opportunity to see his laboratory and the character of his work. He has a well-organized department, and is doing most excellent teaching, judging from his equipment and environment. The museum connected with the college is the largest and most complete I have every seen. The London Medical School has a large faculty, and an able corps of lecturers and demonstrators. Many of the best-known surgeons and physicians in London are connected with this school. Sir Jonathan Hutchinson and Sir Frederick Treves, Bart., are emeritus professors of surgery, but give a course of lectures in clinical surgery during the winter season.

This college has over 300 medical students in attendance upon its different courses of instruction. To become a fully qualified medical practitioner in Great Britain the student must pass (1) a preliminary examination; (2) he must study at a medical school for five years; (3) he must pass a qualifying examination in medicine, surgery and midwifery. Students wishing to graduate at the University of London must pass the matriculation examination of that university. The next step after passing the preliminary examination is to enter a medical school and register as a medical student at the office of the General Medical Council. His name is then enrolled upon the students' register. A perpetual fee of 120 guineas, if paid in one sum, or 130 if paid in installments, at commencement of first, second and third years (equivalent in our money to some $560) is required. The scheme of curriculum is as follows:

First Year—Biology, chemistry and physics, elementary anatomy and physiology, materia medica and practical pharmacy.

Second Year—Anatomy and physiology and histology, lectures and demonstrations. Tutorial classes for the examinations.

Third Year—Anatomy, physiology and histology. Lectures on midwifery, pathology, pharmacology and therapeutics. Hospital medical and surgical practice.

Fourth Year—Hospital medical, surgical and gynecological practice. Attendance on maternity cases. Lectures and demonstrations on medicine, surgery, pathology, morbid anatomy and public health.

Fifth Year—Bacteriology and pathological histology, operative surgery, anesthetics, obstetric operations. Attendance at a fever hospital, a lunatic asylum and a vaccination station and the special departments. Tutorial classes for the final examinations.

A candidate for the diploma of the Conjoint Board, M.R.C.S., L.R.C.P., should pass the first examination in chemistry, physics and biology and pharmacy during the first year. At the end of the third winter session he should pass the second examination in anatomy and physiology, and at the end of the fifth year the final examination in medicine, surgery and midwifery. A somewhat similar course must be followed by candidates seeking degrees and other diplomas.

The London Hospital is a very large and imposing structure, with courts, gardens and detached buildings, covering some 15 to 20 acres

of ground. It presents a vast field for clinical study. The number of in-patients treated in 1909 was 14,990, and out-patients 238,691; operations under anesthesia, 17,639.

Whilst the equipment of the hospital is up to date, I saw nothing different from what we have in the University Hospital in Baltimore. The operating-rooms and wards are more numerous, but no better than ours. I saw only one surgical operation, and this took up so much of my time that I was not able to remain to see the second. I take it that surgical work is about the same in Europe as in America. Our results here are as good as theirs.

I regret that I was not able to visit St. Thomas', Guy's, St. Bartholomew's and other hospitals in London. The object of my visit was rest and pleasure, and not a tour of medical inspection.

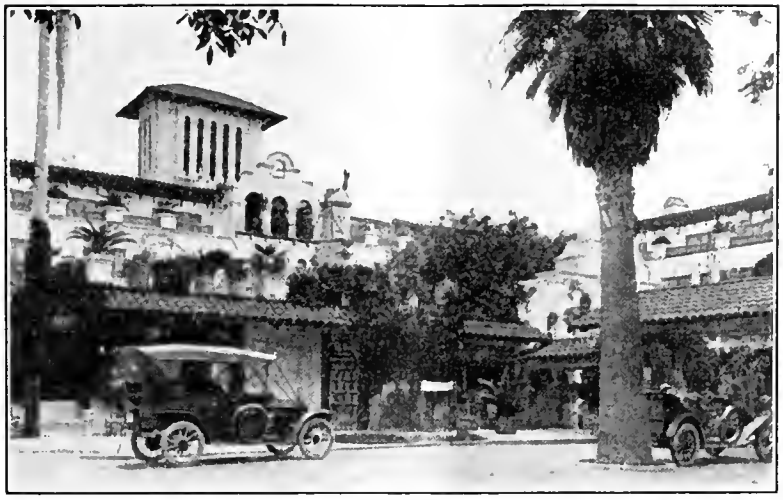
[TO BE CONTINUED.]

SEE AMERICA FIRST.

By Randolph Winslow.

1. FROM BALTIMORE TO LOS ANGELES.

The above caption has become a popular slogan, and we see it repeated in the newspapers and emblazoned on billboards along many of the railway lines of the country. It is a truism only in a restricted sense, as it depends upon what we wish to see as to whether we should see America first or not. First or last, however, one should see his own country, and it is a great satisfaction to the writer that, though he was not able to see America first, he has been able to traverse a large portion of our country during the past few years. The opportunities for distant travel, and the ease and comfort in accomplishing long journeys, associated with a cost that is not excessive, enable one to satisfy a craving which amounts almost to a passion with many of us. The annual meetings of the American Medical Association occurring now on the Atlantic and then on the Pacific Coast, or alternating perhaps between the Great Lakes and the Gulf, offer one the opportunity to see the country, as well as to keep in touch with medical thought and activity. I earnestly commend to my younger professional brethren the many pleasures and advantages incident to attendance on the annual meetings of the great American Medical Association. This year the annual gathering occurred at Los Angeles, Cal., from June 26-30. It is a long step from Baltimore to Los Angeles—about 3000 miles—which can be made by fast train in from four to five days, or, by fast walking, as in the case of Edward Payson Weston, in about 70 days. Not being good on the walk, your correspondent took a fast train. It is said that the longest way round is the shortest way home; certainly the route taken by the special train upon which we embarked was sufficiently circuitous. I left home on June 19 by the Pennsylvania for New York, passing through the tube under the Hudson River into the beautiful new marble station in the midst of the city. Our special train, with stateroom coaches, club and dining cars, electrically lighted and cooled by electric fans, left from the Grand Central Station, and after a beautiful moonlight trip up the Hudson, reached Albany about 10 o'clock, where several prominent physicians and their wives joined us, including our own alumnus, Prof. Wm. T. Councilman of Harvard Medical School. Thence through Buffalo and northern New York in the night, reaching the shore of Lake Erie in the early morning, and Cleveland, which has passed Baltimore in population according to the last census, soon thereafter. From Cleveland to Indianapolis, and thence to St. Louis, where we arrived in the evening, in a little over 24 hours from New York. Parenthetically, I may say that the most unpleasant part of our long transcontinental journey was experienced in passing through Illinois on June 20. At St. Louis we were joined by Drs. Franklin B. Smith and Thomas B. Johnson of Frederick, Md., who completed our company of 109 persons. Missouri was traversed in the night, and the second morning out found us at Kansas City, at breakfast time. Through the rolling prairies of Kansas, with wheat and corn fields extending to the horizon, and with but sparse foliage, we passed rapidly. We were in one of the great agricultural States, and the neat farmhouses and huge red barns attested the thrift and prosperity of the farmers. As the western part of the State was reached the country appeared less fertile, the plains were uncultivated, and great droves of horses and cattle were seen. Night overtook us, and we ran through the southern part of Colorado in the dark. On the morning of the third day we were in New Mexico, on the Santa Fe trail. Descending from the more elevated parts of Colorado we reach the high plains of New Mexico, and pass through a country that has had a histori-



GLENWOOD MISSION INN, RIVERSIDE, CAL.

cal past, for here were settlements and communal towns before Columbus discovered the Western world, and here the conquering Spaniard carried the sword and the cross as early as 1539. New Mexico as seen from the train is a dry, almost desert land, hot in the daytime, but cool and pleasant at night. On the horizon, and often near at hand, are almost bare mountains showing purple in the distance, whilst the plains are covered with a scant growth of sage bush, cacti and coarse grass. There are deeply excavated water courses, often dry or containing only a tiny stream, but wherever water is found in sufficient quantities to be used for irrigating the arid soil, large crops of grain, alfalfa and other products are raised. Human habitations are few and far between, and consist for the most part of low adobe houses, inhabited by Mexicans, with here and there pueblos, or communal houses, of several stories, housing at times large villages of Indians. New Mexico, however, is at the parting of the ways, and new ideas and new conditions are crowding out the old, though at present both exist, side by side. Thus along the railroads flourishing towns, even reaching to the dignity of modern cities, are found here and there, as Las Vegas, with 8000 population, and Albuquerque, which is a much larger place. At all important places there are beautiful and commodious railway stations and hotels, at which the weary wayfarer may disembark and find good cheer and rest. Indeed, all trains stop sufficiently long to enable travelers to get their meals in comfort. The main line of the railroad does not go to Sante Fe, though it

MAGNOLIA AVENUE, RIVERSIDE, CAL.

passes within a few miles of that city, hence I did not have the opportunity of visiting it. At the stations along the line Indians flock to the train to sell their wares to the voyager. The noble red man, including his wife, is by no means a very attractive object, though appearing picturesque at a distance. He appreciates his own value, and will not permit himself to be kodaked until he gets a *quid pro quo* in the shape of a coin. The women seem to value silver coins chiefly as ornaments to be attached to their leggins. At Albuquerque the railroad crosses the Rio Grande on a long bridge, the river being a shallow, insignificant stream. Not far from Albuquerque is the Indian village Laguna, which is a pueblo situated on a high rock and commanding an extensive view of the surrounding plain. Several hundred Indians live at this pueblo, which consists of houses three stories in height, the upper stories being reached by long ladders. These houses are built around a plaza or square, where dances and other ceremonies are held, and where we had a ceremonial dance given in our honor in exchange for a few coins. The dance was not interesting, and in the future I would prefer giving a coin not to see it, rather than to witness its performance. The houses were scrupulously clean, and usually contained a bed, iron cooking stove and a few simple articles of furniture. This pueblo has been in existence for centuries, and was doubtless located at this point on account of its defensibility. The younger Indians are being educated, and adopt civilized dress in many instances, while the older ones continue to wear the characteristic garb of their race. At this point we were deluged with a sudden and torrential rain, the only time we had to seek shelter during our journey until we were leaving Colorado Springs upon our return. We were unable to visit some petrified trees on account of this rain. Continuing through New Mexico, we passed into Arizona in the evening, and much to our surprise found it necessary to draw our blankets over us at night, and were too cool at that. We had ascended several thousand feet in the night, and had come into a different climate. At 5 o'clock on the morning of June 23 we reached the Grand Canyon of Arizona. This is one of the world's wonders, and is unique. It is an immense chasm in the face of the earth, 217 miles in length, 13 miles in width, opposite the El Tovar Hotel, and 6000 feet in depth, and through its floor flows the Colorado River, which has apparently caused the chasm by erosion. The walls of the canyon are almost vertical for several thousand feet, and there are but few places at which a descent can be made. Within the canyon are fantastic mountains and deep valleys and fissures of varying colors—white, gray, yellow, brownish red and black—which, combining with the green of the valleys and the bluish or purplish haze which overspreads the scene, especially as the sun comes over the crest of the mountains, and the silver thread of the river at the bottom of the cleft seven miles away, form a vista that will remain indelibly impressed upon the memory as long as life and reason last. It is impossible to find words to describe the canyon. It is rightly called grand; it is kaleidoscopic; it is

ORANGE GROVE, RIVERSIDE, CAL.

fantastic, grotesque, grim, appalling and beautiful. We spent 30 hours at the Grand Canyon, and on the morning of our departure seven or eight long special trains from Chicago rolled in, filled with doctors and their families, amongst whom were Drs. Hiram Woods, James J. Carroll, Wm. H. Welch and others from Baltimore. This sudden influx of visitors almost swamped the hotel, and we were very fortunate to have been on the spot before the great crowd arrived. Leaving the canyon on June 24, we rapidly descended until we struck the main line at Williams, where we resumed our journey to the west. The town of Winslow, in Arizona, appears to be quite a thriving place. I tried to learn for whom the town was named, but without success. The only answer I received to my inquiry was that it was named after some old man named Winslow. The route westward descended rapidly, and we continued to traverse a dry and parched country until we reached the Colorado River at the needles, and upon crossing the river we were in California. The town of Needles is said to be the hottest place in the United States, and shortly before our arrival the thermometer registered 117 degrees in the shade. It was not unpleasantly hot at the time of our stop, about 6.30 P. M. We were beset by a lot of dirty Mojave Indians, barefooted and unwashed, who offered bead necklaces and other worthless jimcracks for sale. Still traversing a barren country, we continued toward Los Angeles. Early in the the morning of June 25 we reached the fertile and highly cultivated San Bernardino Valley, with its teeming orange groves and beautiful flowers. Soon our train pulled up at Redlands, where we were met by physicians and citizens, who presented us with luscious fruit. We here enjoyed a ride through the city and up to Smiley Heights. Twenty years ago Redlands was a barren waste; now it is as a garden of the Lord for beauty. About that time Albert K. Smiley, a fellow-alumnus of mine of Haverford College, whom I know, bought a tract of land at this point, introduced water and converted what had been a desert into orange groves and parks. The homes here and elsewhere in Southern California are low bungalows, covered with beautiful boganvilla vines and other flowers, and surrounded by well-kept lawns, with palms, cacti, pepper trees, eucalyptus, acacia and other foliage semi-tropical in character, and unknown to us in the East. Roses, geraniums and other flowers grow in profusion, and in summer and winter alike add a blaze of color to the scene. The air is dry and bracing, and though it may be hot in the middle of the day, the evenings are cool and pleasant Rain falls during two months of the year, and during the other 10 months one does not have to carry an umbrella. The chief objection to the climate is the fact that no rain falls, and the country is almost shoe deep in dust. Our next stop was at Riverside, where we were again met and welcomed by the citizens and our sections on the train filled with beautiful fruit. We here had lunch and dinner at the Glenwood Mission inn, a really remarkable hostelry, with its chime of bells, wonderful organ, picture gallery and many curios, to say nothing of the beautiful

THE GRAND CANYON, ARIZONA.

building and excellent fare and service. We were taken in automobiles on a 17-mile drive through orange groves that extended as far as vision reached. At this place also was a botanical garden containing many rare plants and trees, and a collection of cacti of all varieties, perhaps 150 in number. Palms of many varieties were also seen lining the avenues and drives of the city and country. We were in the heart of the citrus section of California, and from this region most of the oranges are shipped. Leaving Riverside about 6 o'clock, we reached Los Angeles at 9.30, and our journey across the continent had been completed.

[TO BE CONTINUED.]

GAS GANGRENE, WITH A REPORT OF TWO CASES.*

By C. W. ROBERTS, M.D.,
Douglas, Ga.

My interest in this formidable complication of surgical practice has recently been aroused by its occurrence in two cases in my service at the Douglas Hospital. I have therefore selected the subject which has just been announced in your hearing primarily because of the occurrence of these, and, secondly, to illustrate in a very impressive way, the fact that, although we may be on the alert for this complication, it will occasionally baffle our efforts at prophylaxis, and before we are aware produce disastrous results in a case which at first would be looked upon as likely to recover.

As one reviews the subject of emphysematous gangrene, spoken of in surgical literature under a voluminous nomenclature, a few striking facts impress themselves upon us, rendering the subject one of sufficient importance to justify its brief discussion before this society. Although it is claimed by some writers that gas gangrene is of rare occurrence, a study of the subject would rather incline us to the belief that it is more frequently met with than one would suppose. The high death rate produced by this infection and the frequency with which the condition is overlooked make it necessary that the practitioner be always on the lookout if he is to be indeed a protector of the lives and safety of his clientele. It is not my purpose to discuss at length the symptoms, pathology and diagnosis of this dreadful malady, because your textbooks furnish this information in a more satisfactory manner. But instead I want to give you the facts connected with the cases referred to in the outset and try to impress upon you the important points, such facts as will enable you to correctly diagnose the trouble when it appears before it is too late for surgical interference. I have referred to the subject of this paper as a complication, not wishing to convey thereby the idea that all cases of gas gangrene are secondary to some injury, but because the great majority are seen to develop after crushing injuries or accidents in which the soft parts are disorganized and contaminated with dirt. In 1891 Dr. Welch of the Johns Hopkins Hospital discovered the bacillus which is now conceded to be the cause of most cases of gas bacillus infection, although there are a few other organisms capable of producing gas in the tissues with practically the same symptoms. To this organism he gave the name Bacillus aerogenes capsulatus, thereby describing it pretty fully as a bacillus with a capsule that grew best without oxygen. This bacillus is found most often in the intestinal tract of mammals and in the soil, particularly the soil of streets, public highways, railroads, etc. It has, however, been recovered from various other sources, demonstrating the fact that the infection may come in a variety of ways. For the purpose of this paper I shall assume that we are dealing with the malady as it most often appears, that is, as a complication of an injury that has been contaminated with soil from streets, public or railroads. As I have intimated, it is in this class of injuries that nearly all fatal cases of gas bacillus infection are seen, and before proceeding to the report of cases it might be of some interest to the members of this association to give here in passing a rather detailed history of the events leading up to the case I wish later to report in order that you may appreciate more fully the facts I shall mention in its connection especially pertaining to the prophylaxis employed and the immediate after-care instituted.

In March of this year a young lady of about 18 was admitted to the Douglas Hospital suffering from the effects of a gunshot wound of the left axillary region. Upon admittance 36 hours after the injury the patient was found in the following condition: A large wound occupying the whole

*Read at the meeting of the Eleventh District Medical Association, Eastman, Ga., June 20, 1911.

of the left armpit, severing the axillary artery and the inner trunk of the brachial plexus, contaminated by dirt and soiled clothing, was found. The patient was very pale from loss of blood, the pulse rapid, expression haggard, temperature 101°. The injured arm was warm and had a good color, although there was considerable swelling. The hand and lower forearm was insensible to touch. The next day after admittance patient complained of severe pain in the arm, but pulse was stronger, slower and appearance of arm was about the same. On dressing the axillary wound I noted a reddish water discharge of a peculiar odor, and around the border of the wound a bleb-like formation was present. In one of the largest of these blebs a dark fluid could be seen, showing through the thin wall, which, on puncture, proved to be of the same character as that oozing from the wound. The next day the nurse noticed early in the morning that the hand and arm were more swollen, there was more complaint of pain, and a distinct discoloration of the hand and arm, producing a rather marbled appearance, had begun, with areas here and there of reddish green, giving the arm the appearance of ecchymoses. On dressing the wound several large blisters were present around the border and about the arm, all containing syrupy fluid of the same appearance and odor as that coming from the wound proper. At the same time gas was discovered in the tissues about the wound, on the chest wall and down to the elbow on the arm. On pressure it escaped from the wound. The diagnosis was no longer in doubt, and I discovered to my chagrin that in an overzealous effort to save an extremity, a desire made more keen by a solicitous father, that I was face to face with a severe case of emphysematous gangrene. Systemic symptoms rapidly ensued, temperature and pulse went up, patient became delirious, and death ended the scene after some 36 hours' suffering. Preparation for amputation was made at a very late hour, but when the patient was anesthetized it was discovered that the condition involved a large area of the chest wall, and amputation could not be done through sound tissues. This deterred us from further effort, and we relinquished hope, I trust, wiser, but deeply convicted of unintentional oversight and misjudgment.

On the heels of this case, and having read carefully and repeatedly the literature on the subject, the second case I wish to report, pertaining directly to railroad surgery, came in for treatment. He was a young negro man of about 22 years of age, well developed and apparently in splendid health. In attempting to stop a car of lumber on which he was riding, the car having been shoved forcibly on to the main line from a switch, in an attempt to connect it on to the train control was lost and the car struck with considerable force another car of lumber, throwing the negro between the cars and piling quite a quantity of lumber upon him. He was extracted and found in apparent good condition save one leg. When he arrived at the hospital he was in splendid condition—no shock, very little loss of blood, good, strong pulse, etc. Examination showed that he had suffered a compound fracture of the tibia and fibula of the right leg, with considerable pulpification of the tissues and laceration of the skin just below the knee. The wound was contaminated by dirt, greasy bits of pants and underwear, and I noted at the time considerable crackling in the tissues, which I took, of course, to be air that had gotten into the wound. Recognizing this case to be one in which gas gangrene readily develops, and with the experience in connection with the case just reported clearly in mind, the patient was anesthetized, the wound laid open, a very thorough cleaning done, in which green soap, bichloride and hydrogen peroxide were freely used, the bones approximated, free drainage through numerous wounds in the surrounding skin established, a few stitches bringing the skin together in places introduced, and a plaster cast applied, immobilizing the extremity. A large window was cut in the cast at this time, allowing frequent inspection and dressing of the wound. I remember to have remarked to an onlooker and the assisting physicians that this case was a good one for the development of gas gangrene, but in reality I least expected that it was going to develop. The patient was put to bed in good condition. Circulation in the foot good. The next morning he complained of pain in the leg. The foot was a little swollen, but warm and of good color. Temperature was 101°, pulse bounding and a little rapid. The dressing was removed, when a rather uncharacteristic fluid was noted escaping from the wound—taken to be an excess of fluid left in the wound in the cleaning-up process. No crepitation could be detected more than was present at the

time of admittance, although this was again noted. The next morning patient complained of a restless night, severe pain in the leg; temperature was 103° and pulse 140. Foot was rather cool, badly swollen, and nails purple. The cast was immediately split its entire length and left for a short while. The foot not only remained cool, but got worse, and when the dressings were removed a little later a sweetish, bloody discharge was noted, a few blebs were seen about the wound and crepitation well diffused. The cast was removed, when it was found that the emphysema extended almost to the ankle. Preparation for amputation was made as hurriedly as possible, but before this could be done patient was in a stupor, had a temperature of 104½° and a pulse of 160. Fifty-two hours after admittance leg was amputated in the middle of the thigh, but patient's condition was not changed by the operation, although he regained consciousness perfectly and rallied from the shock of the operation. The night following he died, the symptoms of a severe toxemia ending the scene.

Now, I have presented the histories of these cases that you may see the similarity, and have given my conduct of them in the hope that you will freely criticise where criticism is due, trusting thereby that some plan of management in such cases may be found that will result in a more favorable outcome.

From a study of the cases reported and the literature of the subject a few practical conclusions may be drawn:

1. This disease develops most often in wounds contaminated by street dirt, railroad dirt and intestinal-tract discharges.

2. Laborers and railroad men are prone to the infection due to their exposure to the above-mentioned sources of contamination of their wounds.

3. Although it would appear that many cases are infected with Bacillus aerogenes capsulatus organism, in which the tissues successfully combat its further development, the disease makes its appearance clinically in relatively few cases—say 1 in 1250 surgical cases exposed to the infection.

4. All wounds contaminated with street or railway dirt should be watched for the development of this infection for 48 hours at least before setting them up with dressings or plaster casts.

5. Although it appears that the organism resists the ordinary antiseptics, such as bichloride, hydrogen peroxide, tincture of iodine and green soap, these having been freely and faithfully used in case 2 reported of my cases, and in various other instances in the literature, these agents should be vigorously used, especially hydrogen peroxide, and then the wounds left open so that plenty of air may come in contact with them all the time.

6. When the complication has developed, as would be determined by a definite, clean-cut clinical picture, the only treatment that one should consider is early amputation through sound structures, when this procedure will remove the infected tissues. If amputation cannot be done as in involvement of the body, proper multiple incisions, with irrigation with hydrogen peroxide, should be resorted to.

7. Treatment to be of avail must be done before 72 hours has elapsed following the injury.

Dr. A. W. Giampietro, class of 1907, writes as follows: "Yours of recent date has been received, and relating to the contribution for the University, I am glad to say that I had long ago thought of, and I have been watching with earnestness, the progress of the endowment fund. To send you now a small contribution is against my determination, but I have decided to contribute a good sum as soon as my affairs have been straightened out. I have been successful in two chemical inventions of highly commercial value, and am dealing with a large concern for the selling of patent rights. The first income I will have, either in money or preferred stock, I will be very glad to contribute a good deal toward this worthy cause. Hoping to hear that you have been successful in raising the balance of the fund, I assure you again of my promise."

We are glad to report that Bishop Luther Wilson, M.D., class of 1877, who was seriously ill in London, is much improved, and will be able to attend the coming conference of the Methodist Church in America.

Dr. J. Burr Piggott, class of 1907, former superintendent of the University Hospital and now located in Grafton, W. Va., was a recent visitor to Baltimore.

THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, SEPTEMBER 15, 1911.

UNIVERSITY OF MARYLAND'S RECORD.

The June examination for licensure of the Maryland State Board of Medical Examiners is now a matter of history. The results have been announced, and it behooves us as one of the institutions vitally interested to carefully inspect the outcome as regards the part played by our men, so that in the future we may fortify ourselves in the weak places and thus better our record. We are proud to announce to friends and alumni that of 35 men standing the examination but three failed to measure up to the standard of excellence necessary to the privilege of practicing medicine in Maryland, giving us the very commendable record of but 8.57 per cent. of failures. One of the men who failed was a member of the class of 1905, which brings us to the point of again urging those who contemplate appearing before the Board to do so as early as possible after graduation, as each year thereafter renders a successful outcome less likely. There were 26 members of the class of 1911 before the Board, with one failure, or 3.846 per cent.; three men of 1910, one of whom failed; four men of 1909, all successful, and one candidate, class of 1904, who passed.

As flattering as the above result is, we wish to assure our alumni and friends that the authorities of the medical department of the University of Maryland will in no wise lessen their vigilance with regard to the manner of men upon whom they confer their diploma, and will strive in the future to wipe out the mortality entirely.

It also gives us unbounded pleasure to announce that one of our men, with an average of 91, shares the honor of leading the State Board; another, with an average of 90, was within close hailing distance, and, taken as an entirety, the grade of all our men was decidedly above the general average of former years. On the whole, we may all take pardonable pride in the outcome. The University of Maryland is willing to be judged by the standard—"By their fruits shall they be known."

LET US ADD YOUR NAME.

We have had a summer of unusual heat and discomfort. We have been threatened with a water famine, and the water we have been furnished by the City Water Department has not been fit to wash in, and has not been such that one would willingly offer to a decent dog to drink. Almost everyone who has been able to get out of the city has gone to more congenial scenes. At the best, the dog days are not favorable times for getting contributions to an endowment fund. We have therefore no large additions to report, but are thankful that we can note a substantial increase during the month.

The subscriptions to September 1 are as follows:

Robinson bequest	$5000
Dr. Hugh Hampton Young, J. H. U.	100
Dr. S. J. Meltzer, LL.D., New York	10
Dr. Gideon Timberlake	25
Mr. H. P. Ohm	10
Dr. Samuel W. Moore, D.D.S.	25
Thomas C. Basshor Company	10
Hospital Bulletin	5
Maryland Medical Journal	5
Miss C. M. Selfe	5
Prof. R. Dorsey Coale, Ph.D.	100
Dr. John J. R. Krozer, 1848	50
Dr. Eugene F. Cordell, 1868	10
Dr. Joseph T. Smith, 1872	10
Dr. W. J. Young, 1872	25
Dr. Thomas A. Ashby, 1873	100
Dr. David W. Bullock, 1873	100
Dr. Robert Gerstell, 1873	5
Dr. Randolph Winslow, 1873	100
Dr. H. T. Harrison, 1874	5
Dr. John D. Fiske, 1875	5
Dr. Charles W. Mitchell, 1881	100
Dr. L. Ernest Neale, 1881	100
Dr. J. M. Hundley, 1882	250
Dr. Henry Chandlee, 1882	10
Dr. J. C. Perry, 1885	100

Dr. B. Merrill Hopkinson, 1885	25
Dr. H. C. Reamer, 1885	10
Dr. Frank Martin, 1886	100
Dr. C. W. McElfresh, 1889	100
Dr. Saint Clair Spruill, 1890	100
Dr. Rupert Blue, 1892	100
Dr. Frank J. Kirby, 1892	50
Dr. Harry Adler, 1895	100
Dr. Jose L. Hirsh, 1895	50
Dr. Joseph W. Holland, 1896	50
Dr. R. W. Sturgis, 1896	2
Dr. Martin J. Cromwell, 1894	50
Dr. Page Edmunds, 1898	50
Dr. L. W. Armstrong, 1900	10
Dr. S. Demarco, 1900	50
Dr. M. S. Pearre, 1900	5
Dr. J. D. Reeder, 1901	50
Dr. Nathan Winslow, 1901	50
Dr. Arthur M. Shipley, 1902	250
Dr. H. C. Davis, 1902	10
Dr. H. L. Rudolf, 1902	25
Dr. Hugh Brent, 1903	25
Dr. G. C. Lockard, 1903	25
Dr. Geo. S. M. Kieffer, 1903	25
Dr. H. J. Maldeis, 1903	25
Dr. R. C. Metzel, 1904	10
Dr. Robert P. Bay, 1905	100
Dr. Jos. A. Devlin, 1906	10
Dr. W. F. Sowers, 1906	25
Dr. Frank S. Lynn, 1907	25
Dr. T. H. Legg, 1907	5
Dr. E. H. Kloman, 1910	25
Total	$78 02

Additions for the month $265.

ITEMS

Dr. Howard J. Maldeis, class of 1903, is home from a trip to the North.

The editor of THE BULLETIN has been favored with the following letter from Dr. Albert Tyler Chambers, class of 1898, who was recently appointed to the School Board of Baltimore City:

"Until I have the opportunity to thank you in person, please accept my profound appreciation of your kind notice about me in THE HOSPITAL BULLETIN of July 15, 1911. It was especially gratifying to see this at a time when I was under fire from certain quarters and having my motives seriously misrepresented. I shall certainly endeavor to measure up to the high standard you predict for me as long as I am a member of the School Board of Baltimore City.

"I desire to state that THE BULLETIN is the most thoroughly read and enjoyed of any journal I take. It not only keeps me in touch with my friends among the alumni, but also keeps me informed about the splendid work being done at the Hospital and University, of which every loyal Marylander will feel proud."

Dr. Samuel William Hammond, class of 1905, of Lambert's Point, Norfolk, Va., writes as follows:

"Referring to editorial department of this month's BULLETIN (August number), that new requirement of the New York Board of Regents comes as a surprise just at this time. Allow me to say that your numerous requests for contributions to the endowment fund have been timely. We'll have to get busy; no question about that. Reminds me of the story of the rabbit that climbed the tree—briefly told. The boy acknowledged that 'rabbits could not climb trees,' but in this particular instance he did 'because he had to or the dog would have caught him.'

"It appears that the time has come when the medical department of the University of Maryland has just got to have a big endowment fund. The merits of the claims for assistance of the old University! Oh, that the people with money could only know! I notice some good responses, but many others are yet unheard from. When the facts and circumstances are put square up to the legislators of good old Maryland, how can they turn it down? Think what the University of Maryland has been to the State—verily a 'fostering mother.' But, in the name of justice and righteousness, the State should aid, and it is believed that the members of the Legislature will see the necessity in this emergency and do their duty. There are enough University of Maryland doctors in Maryland to elect or defeat candidates or members of the Legislature for re-election if they will organize and work to that end."

We hope that the facts will be put "square up to the Legislature" this coming session.

Dr. Randolph Winslow is in receipt of the following letter from Dr. Joseph Angelo Devlin, class of 1906, 168 West 87th street, New York:

"I hasten to add a drop in the bucket; perhaps

later I can add a little more. Anyway, I wish you all success in your endeavor for so worthy a project as the Pathological Department Endowment Fund. I have just returned from Texas; went on a three-weeks' vacation via the Mallory Line to Galveston, and the first vacation I have had in three years. My slight visits to hospitals in Galveston and Houston make me believe that courses in hospital management should be a part of the curriculum. Perhaps Dr. Cordell could set his clock back a quarter of an hour and let someone give a few minutes' dissertation on 'The futility of sweeping dirt from the center of a ward into the corners.' The single exception to the above arraignment is the Southern Pacific Hospital in Houston, which is a new institution.

"You see, you gentlemen of the faculty gave us high ideals, and when we find others not living up to them it hurts a bit.

"Give my very best wishes to Drs. Nathan and FitzRandolph Winslow. I hope they remember me; it's annoying to be forgotten!

"To you, Dr. Winslow, I am still deeply grateful for the good foundation you gave me in surgery. I am striving to adhere to your principles, and thus far I have been fairly successful.

"Good-by and good luck."

Dr. James Wesley Stack, class of 1893, is located at Wye Mills, Queen Anne county.

Dr. Charles Bagley, Jr., class of 1904, has a paper entitled "Intestinal Perforation in Typhoid Fever" in the August (1911) issue of *Surgery, Gynecology and Obstetrics.*

Dr. FitzRandolph Winslow, class of 1906, reports that "The boys have treated me out of sight" while on a recent trip to Cuba and Jamaica.

Dr. C. Clarence Billingslea, class of 1900, Medical Corps, U. S. A., has been ordered to Columbia Barracks for duty. Dr. Billingslea was formerly assigned to the General Hospital, Presidio of San Francisco, Cal.

Dr. Eugene Fauntleroy Cordell, class of 1868, has been visiting in Charleston, W. Va. He writes: "This is my birthplace, and I am proud of it. Have met many old friends." We rejoice with Dr. Cordell in his well-earned vacation, and hope that he may many times again revisit his homeplace with renewed pleasure each time.

THE BULLETIN is endeavoring to secure a biography of the life of each alumnus of the University of Maryland. We would thank each one of our readers if they would send us an account of their life to date.

The publishers of the BULLETIN are very desirous of securing the following copies of the BULLETIN: July, 1905 (Vol. 1, No. 5), January, 1907 (Vol. 2, No. 11), and March, 1908 (Vol. 4, No. 1). We would be more than glad if some of our readers could send us these missing issues.

So far as is known, the living members of the class of 1871 are as follows:

Wm. A. Boylston, Coushatta, La.

Josiah R. Bromwell, 1147 Connecticut avenue N. W., Washington, D. C.

Charles F. Bevan, 807 Cathedral street, Baltimore.

Geo. F. Green, Dublin, Ga.

Henry B. Gross, Jefferson, Md.

John G. Jay, 817 N. Charles street, Baltimore.

Richard H. Lewis, Raleigh, N. C.

J. E. Massey, Rockhill, S. C.

Walter H. O'Neal, Gettysburg, Pa.

Eugene Pendleton, Cuckoo, Va.

David J. Reinhart, 2432 N. Calvert street, Baltimore.

Harrison Tongue, Elkridge, Md.

Geo. G. Thomas, 315 Market street, Wilmington, N. C.

Chas. H. Waters, 1404 Q street N. W., Washington, D. C.

Wm. W. Riley, Cumberland, Md.

C. R. Winterson, Hanover, Md.

Dr. Ejnar Hansen of 41 East 41st street, New York city, class of 1904, writes us that "Everything is, as usual, here in old New York; practice slowly increasing, and, thank heavens, the undertakers so far have not grown rich on my deaths. It seems such a long time since I was in Baltimore, but hope before long to make a short visit there. Since you heard from me last I have increased my family with a son. Best regards to all." Dr. Hansen reports of the son: "He will be one year old September 11. He has his father's name with William van Hadrian put in as a gift."

We extend our congratulations to Dr. Hansen, and hope that he will shortly visit Baltimore. We would be delighted to see him again.

Dr. J. Dawson Reeder, class of 1901, and Mrs. Reeder spent the month of August with Mrs. Reeder's parents, Mr. and Mrs. Thomas Briscoe Gourley, at Holland Point, Calvert county, Maryland.

There is a vacancy in the position of resident physician at the Presbyterian Eye, Ear and Throat Hospital.

We are exceedingly sorry to report that a special jury called in Easton under Judge Philemon B. Hooper has adjudged Dr. James Lux McCormick, class of 1884, as mentally irresponsible. A few years ago Dr. McCormick was well known as a brilliant man, of fine character and acute sensibility.

Dr. Charles R. Diller, class of 1872, of Detour, Md., who was operated on at the University Hospital recently, has entirely recovered. Dr. Diller is the father of Dr. Roland R. Diller, class of 1910.

Miss Lillie Booker Carter, University Hospital Training School for Nurses, class of 1909, who recently underwent an operation at the University Hospital, has recovered.

Dr. Joseph E. Gichner, class of 1890, is home from a trip to Europe.

Amongst our Alumni located in North Carolina are the following:

Old Fort.

T. Morris Chaney, class of 1906.

Pembroke.

Frederick James Pate, class of 1908.

Pioneer Mills.

James Cyrus Black, class of 1906.

Plymouth.

Alpheus Wood Disosway, class of 1905.
W. H. Ward, class of 1881.

Raleigh.

Richard Henry Lewis, class of 1871.
John S. McKee, class of 1907.
Watson Smith Rankin, class of 1901.
Henry McKee Tucker, class of 1899.
Joel Whitaker, class of 1900.

Randalburg.

John Knox, class of 1906.

Red Springs.

Benjamin F. McMillan, class of 1882.
John Luther McMillan, class of 1881.

Reedsville.

John W. McGehee, class of 1904.

Roanoke Rapids.

Hammer Carson Irwin, class of 1905.

Robersonville.

Robert T. Hargrove, class of 1877.
Jesse E. Ward, class of 1904.

Rockingham.

Platt Walker Covington, class of 1908.
Avery Covington Everett, class of 1897.
Frank J. Garrett, class of 1889.
Lorenzo D. McPhail, class of 1900.

Rocky Mount.

Emille Bonniwell Quillen, class of 1904.
William B. Borden, class of 1906.
Mark R. Braswell, class of 1886.
James Battle Phillips, Jr., class of 1903.
Rupert Le Roy Savage, class of 1897.
R. H. Speight, Jr., class of 1901.
George L. Winberly, Jr., class of 1883.

Rougemont.

E. H. Lyon, class of 1903.

Roxboro.

William A. Bradshear, class of 1904.
Bedford E. Love, class of 1904.

Rutherfordton.

Adin Adam Rucker, class of 1908.

St. Paul's.

T. McL. Northrup, class of 1897.

Salisbury.

Herman G. Heilig, class of 1899.
James Earnest Stokes, class of 1892.

Saluda.

E. McQueen Salley, class of 1905.

Scotland Neck.

Henry I. Clark, class of 1879.

Seaboard.

M. R. Stephenson, class of 1881.

Shallotte.

James Albert Stone, class of 1905.

SHELBY.

William F. Mitchell, class of 1889.

SHILOH.

Walter W. Sawyer, class of 1903.

SILER CITY.

Slocomb Rupert Edwards, class of 1908.

SPENCER.

Julian J. Buzby, class of 1904.

STARR.

John B. Shamberger, class of 1890.

STATESVILLE.

Minor Revere Adams, class of 1878.
Archibald A. Cannon, class of 1889.
William Junius Hill, class of 1889.
Henry Fletcher Long, class of 1892.
John Eugene McLaughlin, class of 1886.

STOKES.

Thomas G. Basnight, class of 1904.

SWAN QUARTER.

Richard Eugene Windley, class of 1903.

SWEET HOME.

Edward King, class of 1892.

SWEPSONVILLE.

Thomas R. Williams, class of 1877.

TARBORO.

Walter Curtis Galloway, class of 1874.
Samuel Newburn Harrell, class of 1897.

TRYON.

Earl Grady, class of 1894.

WADESBORO.

Joseph H. Bennett, class of 1894.

WALLACE.

John W. Carroll, class of 1903.

WARRENTON.

Philemon J. Macon, class of 1883.

WARSAW.

James N. Williams, class of 1902.

WASHINGTON.

Jack L. Nicholson, class of 1904.
John W. Williams, class of 1906.

WEBSTER.

Harvey F. Burgin, class of 1874.

WEST DURHAM.

Baird U. Brooks, class of 1905.

WHITTAKERS.

James C. Braswell, class of 1882.
Richard H. Speight, class of 1870.

WHITEVILLE.

William H. Crowell, class of 1895.
Henry B. Maxwell, class of 1902.

WILMINGTON.

Charles D. Bell, class of 1883.
David William Bulluck, class of 1873.
Ernest S. Bulluck, class of 1911.
Thomas Meares Green, class of 1900.
Charles Thomas Harper, class of 1874.
William D. McMillan, class of 1868.
George G. Thomas, class of 1871.
Pride Jones Thomas, class of 1902.
John Charles Wessel, class of 1900.

WILSON.

George W. Lewis, class of 1886.

WINGATE.

James Robert Jerome, class of 1890.
J. Lewis Hanes, class of 1902.
W. Clinton Linville, class of 1903.
Charles L. Summers, class of 1887.

WINTERSVILLE.

B. Thaddeus Cox, class of 1888.

WIT.

William T. Paul, class of 1869.

WOODWORTH.

Victor Morean Eppes, class of 1882.

Dr. Armenius Cleveland Pole, class of 1876, was stunned by lightning, which wrecked the upper floor of his home, 2038 Madison avenue, during a severe storm August 28.

Drs. Henry O. Reik, class of 1891, and Dr. A. J. Neilson Reik, class of 1900, are traveling in Europe.

Dr. Watson Smith Rankin, class of 1901, has the following to say regarding standard death rates in a recent bulletin of the North Carolina Board of Health:

"Symptoms are abnormal manifestations of life. For example, the average pulse is about 72 beats per minute, and a pulse much over or under that average is abnormal or unusual, and, as a rule, indicates trouble. As with the pulse, so with the other phenomena of life; the average and the normal are nearly always the same. Just as there is an average pulse, an average number of respirations, an average consumption of food, an average amount of waste thrown off, all of which constitute what we regard as the normal, so there

is an average number of deaths per year for a given population, an average number of deaths from typhoid, from tuberculosis and other diseases, which constitute normal standards for estimating health or disease conditions in a given community, town or State. Before one can recognize the abnormal he must be familiar with the normal, and before one is prepared to recognize symptoms of disease politic he must know the average total death rate and the average death rate for the different diseases that obtain in a large population. Such death rates have been collected and tabulated by the more progressive States that have recognized the value of keeping an account with death, so that from a large collection of authoritative statistics we can find the normal or average death rate for all diseases combined or for any particular disease. Fifty-five per cent., or 48,000,000 of the population of the United States, are within the jurisdiction of rigidly-enforced registration laws which supply the following statistics: Average annual death rate from all diseases is 15 per 1000; death rate from tuberculosis, 1675 per 100,000; for typhoid fever, 22 per 100,000; for whooping-cough, 11 per 100,000; measles, 10.2 per 100,000, and for malaria, 2.5 per 100,000."

This abstract was also reprinted in the *Journal of the American Medical Association.*

Dr. Louis W. Talbott, class of 1883, of Elkins, W. Va., was a recent visitor to the University Hospital, where his wife was a patient. We are glad to report that Mrs. Talbott has sufficiently recovered to return to her home. Dr. Talbott has practiced successfully in Elkins for a number of years.

Miss Alice F. Bell, formerly superintendent of the University Hospital Training School for Nurses and graduate of the class of 1906, has returned from a visit to Toronto.

Dr. David W. Bulluck, class of 1873, and Dr. Ernest S. Bulluck, class of 1911, announce their association in the practice of medicine and general surgery at Wilmington, N. C., partnership dating from August 1, 1911. Dr. David William Bulluck was born in Tarboro, N. C., June 1, 1853, a son of David William and Mary Margaret (Routh) Bulluck. On the maternal side he is a descendant of Lord Hugh Bryant, who settled in America in 1710; of Major Aaron Lee of Westmoreland county, Virginia, and of William Bulluck of Spithill, England. Through his mother he is descended from William Robert Routh of the famous Routh banking house of London, England. Dr. Bulluck received his literary education during the years of the war between the North and the South, and, owing to the upset conditions then prevailing, was denied the advantages of a finished college course. His primary education was received at the hands of private teachers and in the high schools of Wilkerson and Belmont. In 1870, when but 17 years of age, he entered the medical department of the University of Maryland, graduating in 1873, then only 20 years of age. He served for a year as an interne at the University Hospital, and afterwards was for a time connected with the Associated Medical Charities of Baltimore, and then was for a while a member of the staff of the Mothers' and Babies' Hospital of New York City. While in New York he took special courses under Drs. Robert H. M. Dawbannon and John A. Wyeth, and also took a course in pathology under Professor Adler. Dr. Bulluck is an enthusiastic advocate of the post-graduate medical schools, and for many years spent part of each year in some such school.

Dr. Bulluck began his professional course in Edgecombe county, North Carolina, where he resided until March 14, 1890. He then removed to Wilmington, where he has achieved remarkable success in his profession. He was the founder of the Catherine Kennedy Dispensary and Rest at Wilmington; one of the founders and organizers of the Associated Charities of Wilmington; one of the organizers and for a time president of the Association of Surgeons of the Atlantic Coast Line Railroad Co., and was founder and for six years surgeon to his own infirmary. He is a member of numerous medical societies, visiting surgeon to no less than four hospitals and associations, and has yet found time for many contributions of value to medical journals throughout the country.

Dr. David Bulluck married in November, 1880, Miss Maude Southerland Braswell, daughter of Archibald and Margaret (Clutcher) Braswell, of Edgecombe county, North Carolina. They have three children—David Archie, a chemist; Maude Margaret, a musician, and Ernest Southerland Bulluck, a graduate of the class of 1911, University of Maryland, and author of the paper en-

titled "General Remarks on Epithelioma of the Tongue, with a Brief Report of a Recent Case of Removal of This Organ by Professor Randolph Winslow," which appeared in the November 15, 1910, issue of THE HOSPITAL BULLETIN. Dr. Ernest Bullock was a house student during the session of 1910-1911.

Dr. James A. Nydegger, class of 1892, Surgeon U. S. P. H. and M. H. S., has been granted two months' leave of absence from July 24, 1911.

Dr. Albert Hynson Carroll, class of 1907, who has spent the summer working with Dr. John C. Hemmeter at Woods Hole, Mass., writes as follows:

"Dr. Hemmeter is leaving this week for Baltimore, and I return in a few days also. The work here with him has been intensely interesting, and the course of work I undertook at the Marine Biological Laboratories under such men as Jacques Loeb, Lilly, Newman and Pike was finished satisfactorily. I have endeavored to equip myself as best I could for the future. I came here partly on the advice of Dr. Randolph Winslow, and I am glad that I did. It has been a pleasure to know personally such men as come here each year. Woods Hole is not a place for play. Men come here to work. It is much like a great summer university. Jacques Loeb and others have been keenly interested in the progress of Dr. Hemmeter's investigations. I feel that I have profited by having had the pleasure of assisting him. No one will ever know what an enormous amount of actual labor was involved in the task. We have done intricate operations on hundreds of large dogfish alone, in order to secure the normal as well as the inhibited hearts in sufficient quantity to secure abundant material for analysis. Sand sharks, giant sea turtles etc., have also furnished valuable control material. But you will be much more interested in hearing about it on Dr. Hemmeter's return."

Dr. Horace M. Simmons, class of 1881, is spending the late summer and early fall at Rangeley Lakes, Maine.

Miss Augusta Russell, University Hospital Training School for Nurses, class of 1909, is located at 1820 N. Charles street.

Dr. Henry Boteler Gross, class of 1871, of Jefferson, Frederick county, Maryland, was born near Brownsville, Washington county, Maryland, June 10, 1849, a son of Charles and Elizabeth D. Gross, and comes of American ancestry. He received his primary education in the public schools of Frederick county, Frederick Academy and Mercersburg Academy of Mercersburg, Franklin county, Pennsylvania. He received his medical education at the University of Maryland, entering in 1869 and graduating in 1871. Dr. Gross began his professional career at Adamstown, remaining there for two years; then removed to Funkstown, Md., where he practiced for 14 years. He located at Jefferson in 1887, where he has since built up a successful practice. Governor Smith in 1900 appointed Dr. Gross a member of the Frederick County School Board.

Dr. Gross married Miss Anna Hammond of Frederick county, and has two children—Henry Hammond and Emma Anita Gross.

Dr. Alejandro Ruiz Soler, class of 1906, has removed from Guayama, Porto Rico, to Orecibo, Porto Rico.

Dr. Mackall R. Bruin, class of 1895, who until recently was in Los Angeles, Cal., is now with J. W. Wallace, Newark, Del.

Dr. Walter Henry O'Neal of Gettysburg, Pa., and a member of the class of 1871, was born in Baltimore, Md., September 23, 1849, the son of Dr. John W. C. O'Neal and Ellen Wirt O'Neal.

He attended the Baltimore public schools, and later Pennsylvania State College at Gettysburg. He entered the University of Maryland in 1869, graduating in 1871, afterwards taking post-graduate studies in the department of medicine of the University of Pennsylvania, and also in Bellevue Hospital Medical College in New York city. His professional career began in Gettysburg in 1871, and continued until 1878, when he removed to Parsons, Luzerne county, spending six years there. He then returned in 1884 to Gettysburg, where he has since remained. Dr. O'Neal was physician to Adams County Almshouse from 1871 to 1878; then from 1890 to 1894, and from 1898 to 1900. He was a member of the Town Council of Gettys-

burg, and in 1891 was a member of the City Council. He was elected president of the Gettysburg Water Co. in 1905. He is a member of the American Medical Association and the Pennsylvania State Medical Society, having been its delegate to the meeting of the American Medical Association in 1880. Dr. O'Neal married in 1878 Miss Martha A. Hay of Philadelphia. He has one son, also a physician—Alexander Hay O'Neal, University of Pennsylvania, 1904.

Dr. Robert Parke Bay, class of 1905, Medical Corps, Maryland National Guard, has been made chief surgeon with rank of major, and has been assigned to the First Brigade, vice Major Alexius McGlannan, resigned.

Dr. William Henry Fisher, class of 1905, is one of the best-known physicians of the Eastern Shore. He is living in Centerville, but his practice covers a large territory. Dr. Fisher is exceedingly popular.

Dr. Newman Hall Dewis Cox of Arlington, Baltimore county, Maryland, graduate of the University of Maryland Medical School, class of 1902, is a native of Nova Scotia, born at Kingsport, January 28, 1868, the son of Ebenezer and Emma Dewis Cox. He acquired his earlier education in the public schools of Kingsport and the Halifax Academy at Halifax. He began the study of medicine at the University of New York (now New York University), remaining there from 1891 to 1893, then entering the University of Baltimore School of Medicine, graduating in 1895. He was resident physician at the University Hospital from 1895 to 1896, and during the later part of 1896 was sent to West Africa as medical missionary under the Presbyterian Board of Foreign Missions, remaining there until 1900. He then returned to America and spent one winter at the Johns Hopkins Hospital of Medicine, again receiving the degree of M.D. in 1902. In May, 1902, he began the practice of medicine at Arlington, where he now lives. Dr. Cox is now erecting a new home at the corner of Rogers and Park Heights avenues. Dr. Cox is a member of Brown Memorial Presbyterian Church, and was one of the organizers of the First Presbyterian Church of Arlington, of which he is an elder. He married in 1896 Miss Louisa Henrietta Heyn, who accompanied him to Africa and materially assisted him in his work. They have two children—Newman Elliott, aged 10, and Katherine Emma, aged 8.

Dr. Gideon McD. Van Poole, Major, U. S. A., M. D., class of 1899, was ordered to Dixon, Ill., on August 12 for temporary duty. Dr. Van Poole is also detailed to represent the Medical Department, United States Army, at meeting of Association of Military Surgeons of United States at Milwaukee September 26-30, 1911.

Dr. Robert Lee Hammond, class of 1882, of Woodsboro, Md., has contributed a paper on "Pneumonitis" to the *Medical Brief* for September, 1911. Dr. Hammond says: "I am proud to acknowledge the University as my alma mater. I have tried all my life to avoid anything that would bring discredit to my college and my class." The paper will appear in somewhat different form in two other medical journals in the near future.

MARRIAGES

Dr. Harry A. Rutledge, class of 1907, of 106 Jackson square, and Miss Natalie W. Paynter, daughter of Mr. and Mrs. Warren Paynter, of 2043 Hoffman street, eloped to Jacksonville, Va., and were married there August 24, 1911. The bride announced the wedding to her parents a week later, when good wishes were extended to the couple.

Dr. Arthur Howard Mann, Jr., class of 1890, of Catonsville, was married to Miss Mary E. Elgin of Poolesville, Md., at noon on August 26, 1911. The ceremony was performed at the parsonage of Mt. Calvary Protestant Episcopal Church by Rev. F. B. Staples. There were no attendants. The couple are now at the home of the groom's mother, Mrs. Arthur H. Mann, at Catonsville, Md.

Dr. Mann was born at Baltimore October 29, 1869. He received his primary education at the Friend's School and Oxford School, graduating at the University of Maryland in 1890, and later taking a course in Vienna, Austria. He is well known among the profession in Maryland.

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A HURRIED TRIP THROUGH EUROPE.

By T. A. Ashby, M.D.

(Continued from September 15th Issue.)

After three days of strenuous life in London we were compelled to take leave of this ancient and noble city, which for centuries has been the home of that great and learned and splendid race of people who have dominated the world and made the Anglo-Saxon name respected wherever civilization stands for all that is strong. We recalled the fact that our own ancestors, and those of many of our warmest friends, had been bred on English soil and had carried over to our homes in America the germs of religious freedom and of civic liberty which had made us the great nation we now are. The debt we Americans owe to Old England can only be fully appreciated when we visit her soil and study her splendid institutions, her civil government, the domestic life of her people and her vast contributions to art, science and literature. We often hear on this side of the Atlantic suggestions about the decay of Great Britian; we only see when we visit that country evidences of her growth and prosperity. We have only to contemplate her noble institutions to realize their dignity, solidity and endurance. We should take pride in the fact that we have fallen heir to much that is great and good in her moral and intellectual development, to her wise laws and sound justice, to her honest business maxims and to her high literary culture. We must not deceive ourselves. Great Britian still leads the way in high standards of administration, in thought, cultivation and in civic pride. We have much yet to learn from her. Her people are our nearest kindred. Her blood has warmed our hearts with her noble spirit and pride.

We left London on Tuesday morning at 10 o'clock via Victoria Station for the continent. The train which carried us from London to Newhaven, on the English Channel, passes through a highly-cultivated farming country, showing all the evidences of a high art in crop-raising and pasturage. Every acre of land seems to be in service, and the woodlands are so clean that abundant pasture is afforded for sheep, cattle and horses. Towns, villages and picturesque farmhouses make the landscape pleasing to the eye as we are carried by rail through the counties of Surrey and Sussex to the white cliffs bordering the English Channel.

Our train reached Newhaven at 11.30, when we took passage on the steamer for the French coast. The boat on which we embarked was a small craft, with flat bottom and no keel. It was crowded with passengers, and we had not gone five miles from the shore before we ran into a rough sea, which tossed the steamer fore and aft and from side to side with merciless vigor. The lurches and sudden motions to which we were subjected were irregular and uncertain; many were made sick, and the sight of so much distress was most unpleasant. Whilst I had no nausea, and to that extent was not seasick, I was uncomfortable. Imagine yourself being tossed in a blanket for some four hours, and the reader will realize what we experienced. I must confess I was most happy when we landed in the harbor of Dieppe. The distance across the Channel was some 50 miles, and we were about five hours in covering it. After landing in the ancient city of Dieppe, on the French coast, we had our first unpleasant experience with custom-house officials. With our baggage we were conducted into a long shed, where the custom-house officers in gala uniforms waited upon us and inspected the baggage we had with us. I was asked to open the

dress suit case which contained my clothing. After pulling the contents into a mass of confusion, I was asked if I had any cigars. Opening my coat, I pointed to some half dozen in my vest pocket, the last remains of the supply I had brought from home. With this exhibit I was allowed to escape the revenue duty imposed by the French Government on those who bring cigars and matches into that country. My friend, Mr. Page, was not so fortunate, as he had been more temperate in the use of his cigars than I had been. He still had in his suit case a half box of cigars and a good number of cigarettes. These were seized by the official, and a duty levied on them nearly equal to their purchase price. Mr. Page paid this duty, and very generously allowed me to smoke his cigars before we reached the custom-house officials on the border line where we entered Switzerland. I would suggest to those who smoke cigars and cigarettes to carry a very small supply when they enter French territory. The tax on tobacco in France is very high, and the cigars one buys in that country are very indifferent and very high. Thanks to Mr. Page, I smoked very few French cigars.

The train we took at Dieppe was so crowded that we had some difficulty in finding comfortable seats. Some eight people, men and women, were packed like sardines in a small compartment crowded with hand luggage, with scarcely space for comfortable sitting. I soon made an escape into the passage-way extending along the side of the car its entire length and connecting with open doorways the different compartments. Glass windows open out from the passage-way, giving plenty of air and view from the car. I stood by one of these open windows during the entire run from Dieppe to Rouen and during the greater portion of the distance from Rouen to Paris, a total distance of over 150 miles. The scenery from the window and the privilege of smoking compensated for the discomfort of standing. The run from Dieppe is through a rolling country, presenting many beautiful landscape pictures. The farm lands, forests and meadows show that the hands of man have been busy in the centuries past bringing these lands to the highest state of fertility and productive value. The towns, villages and farmhouses were built almost entirely of brick and stone, with roofs of tile or thatch, giving an old and quaint appearance to the buildings. Many of these buildings look as if they had been standing for centuries. At Rouen we crossed the Seine to the south bank, and from Rouen to Paris, a distance of some 100 miles, the railroad follows the west by south shore all the way to Paris.

Rouen is a very ancient city of Normandy, full of historic interest. It is located on both banks of the Seine, surrounded by very high ranges of hills, which give a very picturesque appearance to the city. At Rouen we enter the Valley of the Seine, and at once come into one of the richest agricultural sections of France. The valley is from two to five miles in width; the bottom lands are level as a floor, extending from the river banks to the foothills and up the foothills from 200 to 500 feet to the skyline, presenting from the car window a picture of rare beauty. These lands are in the highest state of cultivation, every acre covered with green grass or crops of grain. The manner of cultivation is novel to an American. The crops are planted in strips varying in width from 100 to 300 feet, and in length from 100 yards to one or more miles. In one strip is grass; another wheat; another potatoes, and a fourth oats, running parallel. At the time of our trip the wheat and oats were being harvested. The effect presented by the golden grain and the green alfalfa, grass and potatoes was not only striking, but pleasing to the eye. As there are no fences and no buildings, the landscape for miles and miles was one continuous succession of alternating crops. There were no apparent lines between the different farms, which were evidently small, judging from the size and alternations of the sections in cultivation; not a few of these sections were not larger than two or three acres, yet the grass, potatoes, wheat and oats were all growing on these small farms. Men and women were busy cutting and gathering in the wheat and oats, using in most instances the cradle or sickle to cut the crop. I saw less than a half dozen reapers in use during my entire trip through Europe. Women were working in the fields with the men, whilst the cow, the ox and the dog are commonly used to haul in the crops. I shall take occasion later on to refer to these primitive methods of farming in Europe. Another striking feature of farm life which we observed for the first time in a most marked manner in the Valley of the Seine is the almost total absence of farmhouses on these farm lands. The farming classes live in villages

or small towns, and go to their farms on foot, or, very frequently, on the bicycle, to do their work. These collections of farmhouses, with their outbuildings for stock and grain, are located every few miles apart within convenient reach of the farm lands. These homes of the people appear to be well constructed and arranged. They recall the customs and practices of remote times, when personal safety made such settlements a necessity.

In no respect does the method of living in our country and in Europe differ more than in the conduct of the farm and in the domestic life of the people who cultivate the soil.

The farmer in Europe, for the most part, is a peasant, content with small things and living a life of hardship, toil, simplicity and, we believe, contentment. We know what the farm life means to the majority of the farmers of our country. I must express the opinion that we do not appreciate the difference in our favor—the life of independence, of refinement, of solid comfort, of successful results, the larger ways of doing things, but, alas! also the wastefulness, idleness of farm labor and unscientific methods of farm management, so common in many sections. The comparison does not cease here! The peasant farmer in Europe is a man of toil and industry, but he makes both yield results. The few acres of land he cultivates are brought to a high state of fertility, and bring forth crops that amply repay for the labor and care expended upon them. I have never seen such wheat and oat fields as I saw in sections of France and Germany through which I passed. The yield of grain and straw must be enormous, as compared to the average per acre in this country.

I was charmed with the clean and neat appearance of the farm lands, the absence of weeds, undergrowths of brush and other evidences of careless methods of farming. The natural condition of the soil in the larger portions of France and Germany is not as good as we find in many of the States of this country, but intelligent farming has so improved these natural conditions that poor lands have been made rich and waste places have been brought into use. What has been done in European countries, densely populated, is only an indication of the agricultural possibilities of our own country when the growth of population will demand more scientific methods of agriculture. If the thousands of acres of waste lands, of forests and swamps in this country were made to render a useful service under proper management, they could be made to yield more food products than all the farm lands of England, France and Germany combined. Our agricultural possibilities are so vast as to make us land poor.

We reached Paris at 7 o'clock in the afternoon, after a continuous run of ten hours from London. We selected the London and New York Hotel, on account of its central location and from the fact that it is very largely patronized by English-speaking people. We found pleasant rooms, a first-class table and very agreeable people with whom we could converse. After dining we secured a two-seated victoria, driven by a shriveled up old Frenchman, who wore a faded blue livery and a high-crowned leather beaver, with cockade, which gave him a very important look. He spoke enough English to make us understand what he pointed out to us. We gave him instructions to show us all that was worth seeing in two hours. He had evidently acted as a guide on other occasions, for we were shown the most beautiful avenues, buildings and monuments, all illuminated with electric lights. This drive after dark over the city gave us a splendid opportunity to see Paris all brilliant and gay, with thousands of people lining the streets, public parks and cafés. Men, women and children not a few were seated on the pavement around small tables in front of innumerable eating-houses, all eating and drinking merrily, whilst bands of music were playing in many of the larger halls. The crowd seemed good-natured and happy. As we observed these people one might conclude that they were an idle, frivolous set, but such is far from the case. These people all belong to the middle and working classes. They are energetic, thrifty and saving, intent on business during working hours and on simple pleasures after the day's work is over. They take a frugal breakfast and lunch, and for dinner go to the dining houses for more substantial food and, for light wines and beer, which they drink freely, but seldom, if ever, to intoxication. Whilst I saw a great deal of wine and beer drinking in Europe, I did not see a single intoxicated person, nor one that was in the least disagreeable, rude or impolite. After several hours of sightseeing we retired to our rooms for a night's rest. The following morning, after breakfast, we again secured the services of the old Frenchman and his victoria, and were driven many miles through the city and parks, stopping at many of the noted

public buildings for closer inspection and a visit within. In this way we saw Notre Dame, the Pantheon, Louvre, Napoleon's Tomb, Eiffel Tower, Arc de Triomphe, Place de la Concorde, Church of La Madeleine, Place Vendome with its imposing column, Column of the Bastile, Statue of the Republic and many other public buildings, monuments and objects of historic interest. Afterwards we were driven through the Champs Elysées and the Bois de Boulogne, the two most noted parks in France.

I have neither the space nor the ability to write up the varied objects of interest in a way to do justice to the subject or to give a clear description of each. I shall only attempt to point out a few of the sights in which one can always find an interest, which may direct the attention of the reader to them should he ever visit Paris.

These places are all historic, and have been fully written up in guidebooks and in books of travel. It seems unnecessary to do more than mention them. Impressions are very lasting when careful observation has been made. We form opinions from these impressions, and they ever after give shape to our ideas and ideals. In this way our mental faculties create new tastes and sentiments, and cultivate a love for the beautiful and the true in nature, art and literature. The impression we get from a close view of these beautiful buildings, works of art and triumph over nature is that man's artistic taste and sense have been developed to the very highest state of perfection. Notre Dame, for example, is a marvel of architectural beauty and grandeur. I cannot see how it could be improved upon. It certainly surpasses any of the cathedrals I saw in Europe in size and quality of building material and in richness of architectural display. Yet, with all this, it was cold in its effect upon my sentiments, and did not touch the soft spots in my heart, as did the services I attended in St. Paul's, in London, or the sweet tones from the bells in the Cathedral at Cologne. I greatly admired Notre Dame, but did not fall in love with her beautiful walls and stately columns, a most noble specimen of Gothic architecture. For centuries royal coronations, weddings, baptisms and burial services have been conducted within its walls, which, if endowed with the faculty of speech, could tell of joys and sorrows without number.

The visit to the Pantheon was very impressive. This large and beautiful building, modeled after the Pantheon in Rome, from which the building of the Medical Department of the University of Maryland was also copied, is the Westminster Abbey of Paris. It is built of very durable stone, with stately pillars in front and lofty dome above. Its interior is large and handsome, with large columns supporting the roof and dome. In the halls and corridors are statues and statuary representing ancient kings and rulers, men of distinction and renown, in every calling; tablets, memorials, busts all designed to express the esteem in which these dead are held by the people of France. These tributes to the dead are located on the main floor of the building. Following a crowd led by a guide we were conducted to a cellar beneath, a dark and gloomy underground cavern, with avenues and passage-ways leading right and left, in which were deposited in dismal vaults the last remains of many of the great men who have served France in the years long gone by. The guide, with candle in hand, led the way, and as we groped in the dark would halt in front of one of these chambers and discourse in French on the deeds, valor and lives of these long-forgotten dead. I can recall the tombs containing the last of all that remains of Voltaire, Carnot and a few other noted men who did so much to make history in France. Resting in these old underground vaults, where the light of day never penetrates, and where few could ever see their silent tombs, I felt no desire for an immortality which would consign my body after death to a gloomy cavern beneath a stately Pantheon. Far more comforting is it to my soul to feel that when it leaves the house in which it has dwelt the house shall dissolve away and its components shall return to mother earth in a natural way. I do not envy those who covet the privilege of sleeping in this gloomy cave beneath the Pantheon.

To visit Paris and not see the Louvre is an unfortunate oversight. This great storehouse of art, with its enormous buildings and beautiful gardens, covers many acres of ground in the very heart of Paris. It is a grand monument to the genius, culture and artistic taste of the French people. There is perhaps no larger number, and certainly no greater variety, of works of art collected under one roof in any country of the world than can be found in the Louvre. Acres of floor space and walls have been given up to these collections of sculpture, paintings, tapestries, porcelain and china wares, coins and bric-a-brac,

representing the work of all countries and covering every age from prehistoric days to our time. These rare works of art have been selected with the greatest care, and have been arranged and displayed with rare skill. We walked through the rooms and corridors of this enormous building until our feet were sore. I am sure we saw only a small portion of the collections. One could spend weeks in an inspection and still find new objects to interest and instruct his mental faculties. In the halls devoted to sculpture we found many of the busts and statues brought from Egypt, Greece and Rome. The Caesars—Julius, Augustus, Tiberius and Nero—were in evidence here, as in the British Museum, showing the vanity of this family and the very liberal way in which they had themselves represented in marble.

The French have been centuries in gathering together the vast treasures of art now found in the Louvre. Ancient and medieval art predominates over that of modern times. It is in this love for the antique that Europe excels our own country. The time may soon come when we in America will excel European art galleries in modern works of art. We can hardly hope, even with the patronage of our men of wealth, to gather in one musuem any large number of the classical works of art now found in European countries. It is true that enormous prices are now being paid in our own country, and even in our own city, for many of the gems of art held in private galleries in Italy, Germany and France. With our increasing wealth and love of art we may hope in the future to possess many of the old masterpieces so richly prized by the art collector. We must beware, however, of imitations, and not accept all the material offered us as genuine. The large art museums in Europe are owned and subsidized by the Government. Our Government supports no similar institution. The library in Washington and the Smithsonian Institute are the nearest approach which our nation has made to literary and scientific collections. The fine arts, statuary and paintings do not as yet appeal in a large way to the nation's liberality.

There are many other objects of interest in Paris worthy of extended notice. The space at my command does not admit of further details. I can only give the general impression I received and leave the observations made for some future use. The most lasting impression made is that Paris is a most beautiful city, surpassing, in my own opinion, any of the large cities I visited in Europe. Its many miles of broad streets and avenues, lined with splendid and substantial buildings of almost uniform height and width, with highly ornamental fronts—the average height seldom under five stories and very rarely over six or seven, giving an almost uniform skyline—its beautiful open squares and parks radiant with blooming flowers and ornamental shrubs and plants, its grand monuments and bridges crossing the Seine, its clean and well-kept appearance —all indicate the high artistic taste and love of the useful and beautiful of the Parisian people. This love of art enters into the smallest details, for the signs on the buildings, the beautiful displays of goods and wares in the show windows, and even the advertising devices, are made so attractive as to command notice and admiration.

In size, appearance, general bearing and dress the French men and women more nearly resemble the people of our country than do our nearer kindred in England. The crowds of people we meet in the shopping districts of Paris so closely resemble the men and women we meet during our shopping hours on Lexington street, in Baltimore, that we could readily imagine we were at home, did not the wider streets and sidewalks and more elaborate buildings in Paris indicate the difference. The men and women in Paris, with few exceptions, are neatly or handsomely dressed; their general style is attractive; their manner is easy and deferential, all indicating good breeding and kindness of disposition. I believe that the people of our own city have these same characteristics to an equal degree, and we may feel a just pride in the refinement and good breeding of our own citizenship. Long before we have reached the age of Paris, Baltimore should occupy a higher position in culture, art and in all the refinements of life than our Parisian neighbors now occupy. This is claiming a great deal for our city, but I think we have the pride of citizenship and of endeavor, a love for the artistic and beautiful, to go after these results. It is quite certain that no community, however large or small, can rise to the high planes of refinement and culture if in every class of citizens the love of the good and the beautiful is not cultivated side by side with the useful. Among the poor, as among the rich, there are high ideals and sentiments lying dormant which can only be quickened into action and force by the influence

and leadership of those who govern our States and municipalities and control our national life and spirit. In the homes of the poorest classes in rural Europe cleanliness and flowers were more in evidence than dirt and weeds. I saw no pig pens, uncleanly barnyards, decayed fences or filthy fields in any of my travels, but cleanliness, flowers and attractive homes were everywhere. Whilst I did not see the interior of any of these homes, I have no doubt they were as well kept as their exterior surroundings.

During the last two days we were in Paris we were on the constant go, except when eating and sleeping. By making the best use of our feet and of cabs we were able to cover a very large territory and to see many objects of interest. Our muscles and nerve cells were worked to their fullest capacity. We were too tired to remain longer in Paris without a day of rest. We therefore sought in travel the rest of body and relaxation made necessary by our strenuous life.

On Friday, July 21, at 8.20 o'clock, we took the train at Paris for Interlaken, Switzerland. The day was excessively warm, and the cars were crowded with people, many, like ourselves, tourists. Our ride from Paris to Dijon consumed five hours. I do not think I have ever experienced more discomfort in any five hours of my life than on this trip. There was no drinking water to be had on the train, and my thirst was made intense by the heat. At Dijon we secured in the depot a small bottle of stale apollinaris water, too warm to satisfy thirst or to cool one's lips. At Dijon a section of our train was switched off, leaving the locomotive a less number of cars to pull over the Alps. It was not until we reached the Swiss border, at 4 P. M., that any comfort was secured. Here we were detained some 20 minutes until the custom-house officials were able to inspect our baggage. During this interval we found sandwiches, fruits, milk and cold drinks in greatest abundance. I never enjoyed cold water so much in my life. The ride across the Alps after our bodily wants had been supplied was one of the most beautiful experiences of my life. The scenery from the car window defies my powers of description. As we ascended and descended the tall peaks of the mountains, the views of canyons, lakes and mountains in the distance was one panorama of nature in her noblest and wildest forms, whilst the ingenuity and toil of man had made mountains and valleys pay tribute to his industry. Vine-clad hills, grazing lands, meadows of hay, manufacturing establishments, beautiful homes and villages dotted the landscape on every side. At Neufchatel we reached the valley and coursed along the lake until we arrived at Berne. Here two very cultivated young French ladies whose acquaintance we had made on the train said good-bye to us. These young women spoke English with sufficient ease to be entertaining. They were so refined, affable and agreeable that we were more than sorry to part with them.

I may say here that the acquaintance one makes in travel adds greatly to the pleasure. Wherever we went we met with people in our car or boat who proved to be friends and companions of short acquaintance, but of most agreeable manners and kindly ways. We felt that we were with friends on all occasions. The ties of blood are strong, but the whole human family seems drawn together when one goes from place to place and meets with the stranger in a strange land.

Berne, the capital of Switzerland, is beautifully situated in a fertile valley surrounded with lofty mountains with tops covered with snow. The farm lands and meadows were in highest state of cultivation. Large herds of cows were seen grazing in many fields, making cheese and butter the great products of this section. From Berne to Interlaken the railroad followed the borders of Lake Thun, which were lined with beautiful villas, hotels and many small villages, all lit up with electricity. At 9.30 we reached the Royal George Hotel, in Interlaken, after a continuous run of over 13 hours from Paris.

[TO BE CONTINUED.]

THE BULLETIN has been asked to announce that the Western State Hospital, located at Staunton, Va., desires the services of a young physician in the drug department, which pays $50 a month, board and washing. The doctor who referred the request to us states that the duties are light, and the holder of the position would have ample leisure to see any of the work of the institution he would care to. The hospital is a State institution, and there are from 1200 to 1800 patients there all the time. Almost all kinds of mental troubles may be seen there except epilepsy, which is treated in a separate institution. Dr. Joseph S. DeJarnette is the superintendent.

SEE AMERICA FIRST.

By Randolph Winslow.

2. Los Angeles and Vicinity.

Los Angeles is a remarkable city: starting as a Mexican pueblo of 46 persons in 1781, it has developed into a handsome modern city of 319,000 inhabitants, according to the census of 1910. During the past decade it has increased 211½ per cent. in population. With the peculiar optimism of the West, it is prophesied that the population of the city will reach 1,000,000 in 1920. What has caused this sudden increase in the number of its inhabitants? Doubtless many factors; but the location of the city and its splendid climate are probably the most important. The city is about 25 miles from the Pacific Ocean, while behind it at a somewhat less distance is the coast range of the Sierra Madre mountains. The climate is dry, equable, and never oppressively hot or too cold. The nights are always cool, and even in summer a light overcoat is often a comfort. The business portion of the city does not differ materially from similar sections of most other large towns, but the residential streets are lined with handsome homes, which are set apart, surrounded by more or less ground, with beautiful flowers and flowering plants, and vines trailing over the houses. The residences are most of them bungalows, though many are built in the Spanish mission style of architecture, which seems peculiarly adapted to this section of our country. A very strange condition is the presence of hundreds of oil wells within the city limits, and often in the yards of the houses. Equally as strange a sight is that of oil derricks out in the ocean some distance from the shore, in active operation. There are so many places of interest at Los Angeles that a medical meeting is apt to suffer from the truancy of its members. I fear the A. M. A. was no exception in this regard, and I confess that personally I did not attend either the meetings of the House of Delegates, or of the surgical section as faithfully as might have been desirable. Considering the distance from the great centers of population, the attendance was very good, the registration of members being 2153, many of whom were accompanied by their wives and daughters. I think the session was a good one, but nothing surgical of any especial importance was brought out. Socially the meeting was a great success. The president's reception was given in the ballroom of the Shrine Auditorium and was a brilliant affair. With two such men as William H. Welch, the retiring president, and John B. Murphy, the active president of the American Medical Association, receiving together, the occasion was bound to be memorable. I had the pleasure of meeting here Dr. Rupert Blue of the class of 1892, who rid San Francisco of bubonic plague a few years ago, and who is now engaged in exterminating the ground squirrels over a large area of country contiguous to San Francisco. The ground squirrels have become infected from rats

ANCIENT MISSION, SANTA BARBARA, CAL.

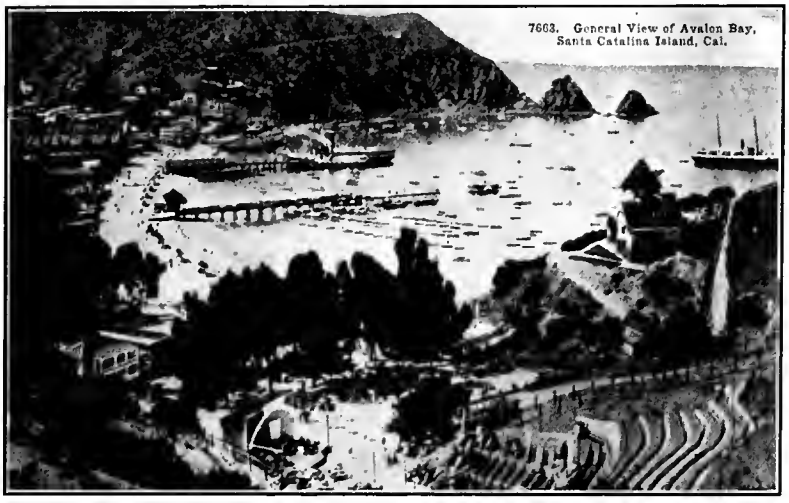
and are agents for the propagation of the plague. A unique entertainment was the smoker and vaudeville performance on the roof of the Hamburger Building. This is an eight-story building with an open and battlemented roof, upon which the smoker was held. It is estimated that from 5000 to 6000 persons were present, and were served with beer without stint, cigars and other refreshments suitable to the occasion, with music, boxing and wrestling as entrées. All the work of the session was brought to a close on the third day, a day earlier than usual, and on Friday Adolphus Busch gave a Spanish luncheon and fête at his magnificent sunken gardens at Pasadena. The day was beautiful and the gardens and grounds wonderful; bands discoursed music, and Anheuser-Busch beer flowed in streams, or rather from bottles. Beeves and hogs were barbecued, and the crowd thronged and surged in its efforts to reach the serving tables and did not get much but ruffled tempers, rumpled clothes and indigestible meat. The power of wealth is well exhibited in the transformation of barren and rocky hillsides and rubble vales into the loveliness and beauty of the Busch gardens. Pasadena, which is only 10 miles from Los Angeles, is the rich man's colony, and here we see the magnificent homes and beautifully kept grounds of the multimillionaires. The suburban, or interurban, electric lines of Los Angeles radiate in every direction, and for a small fare one can travel almost anywhere within a radius of 100 miles. Twenty-five miles to the west is San Pedro, the seaport of Los Angeles, where the Government has established huge breakwaters to render the harbor safe. We saw here quite a large squadron of United States warships, as well as many large coastwise steamers. Off the coast 27 miles from San Pedro is Santa Catalina Island, a picturesque and beautiful island, 22 miles long and from one to eight miles wide, and very mountainous and rugged. At one time it supported a large population of Indians, but these have all disappeared, and the permanent inhabitants are but few. It is reached by ocean steamer from San Pedro, and on the day the writer made the trip the skies were bright and the sea smooth, and but few persons yielded to mal de mer. The landing place is Avalon, a seaside resort, with some fair hotels, but most of the visitors prefer to live in tents in large camps, where, doubtless, the formalities and conventionalities of society are largely dispensed with. For the transient excursionist the most interesting thing is a view of the marine gardens, or aquatic plant and fish life through the glass bottomed boats. The water is very clear and objects many feet below the surface can be distinctly seen. Boys and young men clad only in trunks, and with limbs and necks of a deep tan color, dive from boats for coins tossed into the water, and but seldom do they fail to catch the coin before it reaches the bottom. They also dive for abalone shells, which they bring up from the bottom at a depth of 25 or 30 feet and sell to passengers on the boats. It detracts somewhat from the interest of the procedure to learn that the shells have been

BUSCH'S SUNKEN GARDENS, PASADENA, CAL.

placed in the water by the same individuals, and that they did not grow there. It certainly is a strenuous way of earning a livelihood, and one does not begrudge them the stipend they receive. There is a fine aquarium at Avalon, where fishes found on the Pacific Coast can be seen. Seals also resort to this beach, where they are fed; while on the more remote and inaccessible parts of the island wild goats are to be found in abundance, the hunting of which has become a famous sport. These goats are not any peculiar species, but simply the ordinary billy and nanny that have reverted to a wild state from lack of care.

On the trip to and from Catalina we saw a number of flying fishes that were several times as large as those I have seen on the Atlantic Ocean, and which flew a much greater distance. They looked like birds as they skimmed over the water. As has been stated, the suburban electric roads of Los Angeles are remarkable. From the Pacific Electric Railway station trains run in all directions: to the coast, to Long Beach, Venice of America, San Pedro and other points; to the mountains, to Mount Lowe, with its remarkable inclined railroad, and to Mount Wilson, 6000 feet in height, from which a magnificent view of the surrounding country can be had; to San Gabriel Mission, one of the remaining Spanish missions that was built in the latter part of the eighteenth century by the Francisan monks and that are still kept up and used as places of worship. Most of these missions, established by Fra Junipero Sierra, along the coast of Southern and Central California, are now in ruins, but several are still in a good state of preservation and are objects of interest, and doubtless of veneration, to many. Whitier is a town established by Quakers, 13 miles from Los Angeles, where there is a flourishing college and a prosperous farming community, which with many other towns and cities, are found within a radius of 30 miles and are easily and speedily reached by the electric railway system.

The hotels of Los Angeles are mostly new and handsome, and one can get any accommodation that he may desire. If he prefers to live at a small cost, he can get his meals at a caffeteria, which is a restaurant at which one helps himself, and for 25 to 40 cents can get as much as he can eat. If he prefers more style, there are many other places of entertainment where he can find style, but will not fare any better. Los Angeles appears to be a place where the conditions of life are exceptionally easy and agreeable.



AVALON, SANTA CATALINA ISLAND, CAL.

Dr. William Benjamin Borden, class of 1906, First Lieutenant, Medical Reserve Corps, U. S. A., has been ordered to proceed to Manila, P. I., on the transport sailing from San Francisco on or about January 5, 1912, and on arrival will report in person to the commanding general, Philippine Division, for assignment to duty.

GUNSHOT WOUNDS OF THE SPINAL CORD.

By C. L. Dries, '11,
Senior Medical Student.

Wounds by gunshot, especially those which involve the spinal cord, are always of a very serious import. In recent wars the frequency of wounds involving either the spine or the spinal cord appears to have somewhat increased.

In the American Civil War about one-fourth of 1 per cent. of all wounds were wounds of this region.

In the Spanish-American War and the Philippine Insurrection this proportion was more than doubled.

The increase in frequency of fracture of the spine, with or without involvement of the spinal cord, is probably due to the greater penetrating power of the modern bullet. With the older bullets not only did the bullets not penetrate so deeply into the tissues, but they were frequently arrested by the resistant structures about the spine or by the vertebrae.

The mortality in recent wars is high, higher even than with the older missiles, this probably being due to the fact just named, that is, that the modern bullet is more likely to pass through the vertebra and to reach the cord.

In the Civil War 55.5 per cent. of all spinal fractures ended fatally.

In the Spanish-American War the mortality was as high as 66.6 per cent., and in the Anglo-Boer War the mortality in 48 cases was 58.3 per cent.

Infection enters as an important factor, especially in cases which terminate fatally. When infection occurs, the resulting meningeal inflammation is even more apt to end in death than in similar involvement of the intracranial structures.

In involvement of the cord, the cord may be concussed, compressed or entirely destroyed.

Concussion, unless it is severe, is usually more or less rapidly recovered from; but when the cord is compressed, or is partly or wholly destroyed, the injury assumes a very serious character.

Degenerative changes often go on with astonishing rapidity, together with deep sloughing bed sores and cystitis.

The surgeons in the Boer War spoke particularly of the painful and distressing features in their cases, and state that no cases in the hospital seemed more hopeless or more distressing.

Concussion of the spinal cord by gunshot is due to the shock of impact of the missile or the molecular vibrations set up by the passage of the missile at high velocity near the cord. The effect of such injury may be transitory pain and loss of muscular control or complete paralysis, and anesthesia with persistent pain and general neurasthenic symptoms.

Compression of the cord may be due to hemorrhage, to depressed fragments of bone, or to pressure from a lodged missile. Unless the compression of the cord is great, complete distal suspension of the function of the cord does not occur, but these cases are so apt to be complicated by partial destruction of the substance of the cord, or pronounced concussion, that they are difficult to diagnose.

Destruction of the cord may arise either as a result of direct injury by a bullet or an indriven bone fragment, or may occur as the result of the transmission of energy from the missile at high velocity passing near the cord. The shattering of the cord by molecular vibration has been noted by all observers as a result of the use of the modern high-velocity projectile. It has occurred in cases where the bullet barely grazed the membrane of the cord. The cord is reduced for some extent to a custard-like material, and is completely and permanently destroyed, as though it had been severed by a missile.

In cases of involvement of the cord, the determination of the exact conditions is often difficult, and early in the case it may be impossible. Shock is usually marked by paralysis and anesthesia of the parts supplied from the cord below the injury, paralysis of the bladder and rectum, and loss of reflexes commonly occur at once, whether the injury is a complete destruction of the cord or not.

The complications and sequelae following injury to the cord are spinal meningitis, myelitis, diseases of the kidney, and bed sores.

Meningitis and myelitis are usually due to direct infection, and may be either local or general. The general form is quickly fatal. In the degenerative changes which follow injury without infection the course of the case is slower, but the patients usually die from the conditions connected with cystitis, renal disease and decubitus.

Treatment.—The treatment of gunshot fractures of the spine is always difficult unless the case

be one of those simpler forms of fracture without involvement of the cord or injury to nerves. The great majority of spinal wounds are made by bullets, and are deep and small, making the determination of the amount of injury to the cord very difficult. If the bullet has passed through, some opinion may be formed from its course, but if the bullet is lodged, no such information is possible.

The depth at which the cord is placed, the magnitude of the operation required to disclose it, and the fatal effects which follow infection of the meninges have all to be considered, and make exploratory or reparative operations possible only in the hospital, where aseptic technique can be employed and where the necessary time for the operation can be given.

An X-ray should be employed to locate the missile, and an exploratory laminectomy may be done.

In cases of complete division of the cord in bullet or stab wounds, the tissue of the cord on either side of the lesion is not as contused as in complete crushes due to fracture. Hence they are more suitable for suture of the cord, which does no harm and may help to settle clinically the question of the regeneration of the cord.

If no operation is done, avoidance of probing, cleansing of the wound area, an aseptic dressing and treatment of the cord symptoms fulfill the indication.

Braun removed a bullet from within the cord, but the system did not respond to the stimulants exhibited, and the patient died the same day. He was perfectly conscious up to the last moment, and there were several respirations observed after the action of the heart had ceased entirely.

In 54 cases of gunshot injury of the vertebrae, complicated by traumatic lesions of the cord, 42 were fatal and 12 partially recovered and were discharged with varying degrees of physical disability.

Fourteen cases of contusions and concussions (commotion) are recorded, with a mortality of 100 per cent.

The 54 cases where injury of the cord is mentioned cannot possibly include all in which that complication existed.

Prewitt collected 24 cases operated on, and 25 not operated on, with a mortality of 54 per cent. in the former and 68 per cent. in the latter.

Schmidt gives 62.5 per cent. of cures in cases operated upon and 24 per cent. in those not operated on. These figures speak strongly in favor of operation, at least where operation is clearly indicated.

TROPICAL ABSCESS OF LIVER.

By G. Y. Massenburg,
Senior Medical Student.

AMEBIC ABSCESS.

Amebic abscess, a complication of amebic dysentery, is a condition rarely found in this climate, but is quite common in the tropics; hence the name, Tropical Abscess.

The abscess may occur during an attack of dysentery, or it may follow at any time after recovery from the primary infection. Cases of tropical abscess have followed an infection two years previous.

The abscess may be situated in any part of the liver, but is usually found in the right lobe and toward the convex side. As to the position of the abscess, so are the local symptoms and signs. Pain of a dull, heavy character is first noted occurring over the liver area and upper abdomen. An abscess situated in the upper right lobe on pressure upon the right phrenic plexus may give rise to sympathetic pain in the right shoulder. As the abscess develops and approaches the pleura above or the peritoneum below, so does such pain occur as is characteristic of pleurisy and peritonitis. It is only when these structures are involved that the pain is severe.

At about the time of onset or noticeable pain there is usually a slight evening rise of temperature, preceded by chilly sensation or even a mild chill, and followed in the night by a drenching, exhausting sweat. This is usually the character of the rise of temperature, but cases at times run a subnormal temperature and others run a more or less constant temperature.

The constitutional symptoms are those of a toxemia; thirst, slight digestive disturbances and diarrhea are present, but at times, when the abscess is late in following primary infection, constipation may exist. There is also quite a loss in weight, and the patient becomes quite anemic.

On physical examination the signs depend upon

the position of the abscess. The usual position is in the upper right lobe of liver. There will be noticed on inspection a slight bulging of the intercostal spaces, pressure will show some tenderness over that area, there will be noticed dullness above the normal limits. If the abscess be large there may be some interference with breathing on that side, due to pain from involvement of the pleura, also because of the encroachment of the abscess upon the lung tissue. When the pleura and lung are involved cough is usually present, but no expectoration noticed unless rupture has taken place into a bronchus, when a dark brown viscid pus is discharged.

If the abscess is in the left lobe or on the under surface of the liver, so are the physical signs.

The abscess in its downward growth usually ruptures into the peritoneal cavity. It may, however, rupture into the stomach or any part of the intestine. It rarely ruptures through the skin, and one case is on record where rupture took place into the pericardial sac.

Amebic abscess usually runs a course of a few weeks or months, but occasionally it is quite short, the patient dying in about a week. Some cases are very chronic, running a course of a year or more.

In the diagnosis of amebic abscess it is most important to get a good history, and a great deal depends on previous attacks of dysentery.

The ameba are found in the bowel at times, and often clinches the diagnosis.

When the symptom complex seems to be quite indicative of amebic abscess, some authorities advise probing with an aspirating needle into the liver. The point selected is in the mid axillary line, between the eighth and ninth ribs; from this point the greatest area of liver can be reached, and especially the seat of most frequent occurrence.

Early diagnosis is important if a successful outcome is to be hoped.

The prognosis is very grave, especially so when the patient is an alcoholic, and where multiple abscesses exist.

The treatment (prophylactic) must be a betterment in sanitary conditions. The protection of the water supply, as this is the most frequent source; in short, careful guarding against any food or substance taken into the digestive tract. *Prophylaxis* as regards the individual must also be considered, especially as to those things which have to do with lowering resistance of the liver, such as abstinence from alcohol, condiment eating. Sudden chilling of the skin must be carefully guarded against, that the internal organs be not congested.

The surgical treatment is to go through the abdominal or thoracic wall, following the course of a canula that has previously been inserted. If adhesion between the parietal and visceral layers of the peritoneum have not formed you may sew the one to the other and wait 24 hours for adhesions to form, or gauze may be tightly packed between the two layers of peritoneum and the further course of the operation pursued. It consists in going into the abscess with a dull instrument that the hepatic vessels be not severed, and so obviate what might be severe and obstinate hemorrhage. Some surgeons employ actual cautery in opening the cavity.

The pus is evacuated, but the cavity not curetted, as there is rarely formed an encysting membrane, and only liver substance lines the cavity, irrigation may be done, and injections of quinine are sometimes made; that drug is supposed to be germicidal to the ameba. Several gauze drains and a rubber tube should be left in the wound. It is very important that a frequent change of dressing be done.

Another operation is first locating the abscess with an aspirating needle, taking it out, the aperture in skin is enlarged, a tractor with a canula about three-eighths inch in diameter is inserted and into this is put a piece of rubber tubing tightly stretched over a stylet, the tractor and stylet are removed, leaving the tube to drain the cavity.

Dr. Ralph Steiner, class of 1883, of Austin, Tex., was a visitor to Baltimore September 15. He was interviewed by a reporter on the Baltimore *American* staff, and in the course of the interview said:

"I am back in this old town, which I have never ceased to love, on business for the State. We are in need of two steam vessels for the quarantine service at Galveston, and my mission is to secure them here. Texas would be in splendid condition except for the partial failure of the cotton crop. I had thought to raise 800 bales this season, but by reason of the drouth will not gather over 400 bales. The whole State is similarly affected, and our income from the biggest source—cotton—is going to be heavily reduced."

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, OCTOBER 15, 1911.

A GOOD SCHOOL OR NONE.

The Medical School of the University of Maryland has always maintained a good standard and has had a long and honorable career. It has not been perfect, nor perhaps has it always been as rigid as it should have been, nevertheless it has always stood for high ideals and proficiency. It is absolutely honest; it does not profess to do those things it cannot do, and it does those things it professes to do. Some years its record before the examining boards has been bad, in other years good. In 1910 its record as reported was bad, though more than usual effort had been made to eliminate bad material and to graduate only the good. This year we think the record will be good. The instruction is good, the examinations are sufficiently rigid and are impartial, and students have been turned down with a liberal hand; but a system was in existence that to a large extent was responsible for our poor showing, viz., permitting students to have credit for branches passed, instead of making them take the whole year over when they failed to graduate. In this way many men slipped through. This has now been stopped; men are not allowed to carry more than two conditions from one class to another, and if they fail to graduate and are permitted to return they must repeat the whole year. Moreover, but few will be allowed to return if they fail in the senior year. Of the 13 who failed in 1911, only three will be permitted to return, two with averages over 80 and one a foreigner who could not express himself well in English. We believe this new regulation will pretty well stop the failures before the examining boards. Another loophole has also been closed, that of accepting credits from other schools. Hereafter credits will be accepted only from creditable schools, and those who wish to change from doubtful institutions will be required to pass examinations to determine their proficiency. The Faculty is determined that we shall have a good school or none.

THE 105TH SESSION.

After a period of four months' quietude the campus of the University of Maryland is again alive with life and animation. The benches in front of the old building are again doing service. The hilarious voice of the student is again to be heard. It is sincerely hoped that the bright faces now in so much evidence will not be shrouded when next June rolls around. We are glad to announce to our alumni and friends that the 105th annual and consecutive session of the medical department is now in full swing, and that all indications point to a large attendance and a prosperous year. The enrollment at this time is, in fact, larger than on the same date last year. Owing to the stringent regulations of the Board of Regents of the University of New York, and the advanced requirements of the Associations of American Medical Colleges, more care than ever has been exercised in accepting students from other institutions, which, we believe, will result in a lessened failure of our graduates before State licensing boards.

DO IT NOW!

"The days of our years are threescore years and ten; and if by reason of strength they be fourscore years, yet is their strength labor and sorrow." The writer has not reached the alloted threescore years and ten, and he never expects, by reason of strength, to reach fourscore years, yet he knows something of both labor and sorrow. Anyone who undertakes to raise an endowment fund for a medical school will certainly become well acquainted with labor, and before he accomplishes his task he is also likely to be on intimate terms with sorrow. If the writer could live the threescore years and ten in health and strength, he is confident that he could

raise the $100,000 needed for the department of pathology, but as he has no guarantee that his life and strength will be spared for that length of time, and as the endowment is urgently needed now, he begs his friends not to delay sending in their contributions. Not to be too lugubrious, however, he is pleased to announce that the subscriptions for September were by no means bad, and that a substantial addition has been made to the fund both in pledges and cash.

The subscriptions to October 1 are as follows:

Robinson bequest	$5000
Dr. Hugh Hampton Young, J. H. U.	100
Dr. S. J. Meltzer, LL.D., New York	10
Dr. Gideon Timberlake	25
Mr. H. P. Ohm	10
Dr. Samuel W. Moore, D.D.S.	25
Thomas C. Basshor Company	10
Hospital Bulletin	5
Maryland Medical Journal	5
Miss C. M. Selfe	5
Prof. R. Dorsey Coale, Ph.D.	100
Dr. John J. R. Krozer, 1848	50
Dr. Eugene F. Cordell, 1868	10
Dr. John G. Jay, 1871	25
Dr. Joseph T. Smith, 1872	10
Dr. W. J. Young, 1872	25
Dr. Thomas A. Ashby, 1873	100
Dr. David W. Bulluck, 1873	100
Dr. Robert Gerstell, 1873	5
Dr. Randolph Winslow, 1873	100
Dr. H. T. Harrison, 1874	5
Dr. John D. Fiske, 1875	5
Dr. R. H. P. Ellis, 1877	10
Dr. Charles W. Mitchell, 1881	100
Dr. L. Ernest Neale, 1881	100
Dr. E. L. Meierhof, 1881	50
Dr. J. M. Hundley, 1882	250
Dr. Henry Chandlee, 1882	10
Dr. J. C. Perry, 1885	100
Dr. B. Merrill Hopkinson, 1885	25
Dr. H. C. Reamer, 1885	10
Dr. Frank Martin, 1886	100
Dr. John R. Winslow, 1888	50
Dr. C. W. McElfresh, 1889	100
Dr. Saint Clair Spruill, 1890	100
Dr. Rupert Blue, 1892	100
Dr. Frank J. Kirby, 1892	50
Dr. Martin J. Cromwell, 1894	50
Dr. Charles T. Harper, 1894	50
Dr. Harry Adler, 1895	100
Dr. Jose L. Hirsh, 1895	50
Dr. Joseph W. Holland, 1896	50
Dr. R. W. Sturgis, 1896	2
Dr. Guy Steele, 1897	15
Dr. Page Edmunds, 1898	50
Dr. L. W. Armstrong, 1900	10
Dr. S. Demarco, 1900	50
Dr. M. S. Pearre, 1900	5
Dr. J. D. Reeder, 1901	50
Dr. Nathan Winslow, 1901	50
Dr. Arthur M. Shipley, 1902	250
Dr. H. C. Davis, 1902	10
Dr. H. L. Rudolf, 1902	25
Dr. Hugh Brent, 1903	25
Dr. G. C. Lockard, 1903	25
Dr. Geo. S. M. Kieffer, 1903	25
Dr. H. J. Maldeis, 1903	25
Dr. Howard J. Iglehart, 1903	25
Dr. R. C. Metzel, 1904	10
Dr. Robert P. Bay, 1905	100
Dr. B. F. Tefft, 1905	100
Dr. Jos. A. Devlin, 1906	10
Dr. W. F. Sowers, 1906	25
Dr. Robt. W. Crawford, 1906	25
Dr. Leo Karlinsky, 1906	20
Dr. J. F. Hawkins, 1906	25
Dr. Frank S. Lynn, 1907	25
Dr. T. H. Legg, 1907	5
Dr. E. H. Kloman, 1910	25
Dr. A. Sagebien, D.D.S., Cuba	5
Total	$8202

Additions for the month $400.

ABSTRACT

The following abstract was taken from the *Lancet* of September 2, 1911:

In the *Maryland Medical Journal* for July Prof. R. Winslow has reported two cases of a remarkable injury—complete transverse destruction of the spinal cord from a bullet wound without penetration of the spinal canal. In the first case a man, aged 24 years, was shot with a pistol, the bullet entering in the left seventh intercostal space just behind the mid-axillary line. He fell to the ground paralyzed below the umbilicus. There was severe pain in the upper abdomen and chest. He was taken to the hospital, where he was found to be completely paralyzed both in sensation and motion up to a line extending

round the body 1½ inches under the umbilicus in the middle line in front and curving upward along the upper border of the twelfth rib to the spine. Above the paralyzed region was an area of hyperaesthesia three inches wide. The paralysis was of the flaccid type. Cremasteric and slight plantar reflexes were present, but the patellar and tendo-achillis reflexes were absent. He could not pass urine and the bowels acted only after enemata. Kernig's and Babinski's signs were absent. Complete transverse destruction of the cord at the ninth dorsal segment was diagnosed. Irregular exacerbations of temperature supervened, but the general condition was good. A radiogram showed the bullet in or about the body of the eighth dorsal vertebra. Believing that the spinal cord was completely divided, Professor Winslow determined to explore the spinal canal, and, if justifiable, suture the cord. He removed the laminae of the seventh, eighth, ninth and tenth dorsal vertebrae. There was no blood in the canal and the dura was uninjured. The dura was opened widely, permitting the escape of much cerebro-spinal fluid. The cord did not appear to be altered, though subsequently some grumous material escaped from it. There was nothing more to do than to close the wound. Healing took place by first intention and the patient was neither improved or made worse by the operation. The fever continued, he became emaciated, and bed sores formed, but he was living at the time of the report.

In the second case a girl, aged 18 years, was shot in the left side of the neck. The bullet entered about the middle of the sternomastoid muscle and passed downward, inward and backward. She fell forward with paraphlegia, paralysis and dilation of the left pupil. There was complete anesthesia below the first rib of the left and the third rib on the right side. Retention of urine and feces ensued. The diaphragm was not affected. Sensation and motion partially returned in the left arm. The reflexes were abolished and bed sores quickly formed. Bullet wound of the second dorsal vertebra, crushing or otherwise injuring the cord, was diagnosed. Death occurred on the twenty-second day. The necropsy showed that the bullet passed behind the brachial plexus, between the anterior and middle scaleni muscles, broke the tip of the transverse process of the seventh cervical vertebra, penetrated the body of the second dorsal, cut a piece from the first rib, and impinged on, but did not penetrate the spinal canal. Bloody serum in the canal and spinal meningitis were present. The cord was not penetrated or compressed, but was disintregated and much reduced in size opposite the position of the bullet. In these cases the injuries appear to be due to concussion of the spinal cord, though it is difficult to understand how complete transverse destruction of the cord can occur without direct impact. However, its occurrence is recognized.

During the American Civil War a number of such cases was observed. In his "Manual of Military Surgery," written for the use of surgeons of the Confederate Army, the late Prof. J. Chisolm stated that concussion produced by explosion of a shell near the back was not an infrequent injury, and that its symptoms were pain and impairment of motion and sensation in the lower limbs, amounting at times to paralysis. Colonel W. F. Stevenson states in his "Wounds in War" that concussion of the cord without fracture of the spine may be produced by shell fragments or small arm projectiles, and that paralysis below the injury may be absolute, but if secondary changes do not take place in the cord, and hemorrhage into the spinal cord does not occur, recovery may be rapid and complete. The treatment of complete division of the spinal cord is still a mooted question. Psysiologists declare that regeneration is impossible once the cord has been divided, but three cases of suture with slight improvement have been recorded by American surgeons. The first surgeon to perform the operation was Dr. Francis T. Stewart of Philadelphia. In a case of bullet wound of the dorsal spine he found the cord completely divided with an interval of three-quarters of an inch between the ends. He freshened the edges and sutured the cord with three chromised catgut sutures. The patient, who had been paraphlegic, soon showed improvement, and sixteen months after the operation could perform various movements with the toes and legs, and had control over the urine and feces.

ITEMS

Dr. John McMullen, class of 1895, Past Assistant Surgeon, U. S. P. H. & M. H. S., is stationed in Baltimore.

Dr. Eugene Hagan Mullan, class of 1903, is a member of the United States Public Health and

Marine Hospital Service, commissioned as assistant surgeon.

Dr. James M. Craighill, class of 1882, has removed his offices and residence to the Walbert, Lafayette avenue and Charles street.

The following appear to be the living members of the class of 1873:

Thomas A. Ashby, Baltimore, Md.
Benjamin R. Benson, Cockeysville, Md.
Robert M. Bolenius, Lancaster, Pa.
David W. Bullock, Wilmington, N. C.
Truman E. Fairall, Tecumseh, Neb.
Virginius W. Gayle, Kansas City, Mo.
Richard Gerstell, Keyser, W. Va.
Robert Gerstell, Keyser, W. Va.
Wm. A. Hinchman, McKeesport, Pa.
Jas. W. Humrichouse, Hagerstown, Md.
Wm. S. Maxwell, Still Pond, Md.
T. Morris Murray, Washington, D. C.
Frank W. Pearson, Baltimore, Md.
John H. Rehberger, Baltimore, Md.
Charles E. Sadtler, Baltimore, Md.
Chas. E. Scholl, Camden, Ind.
James A. Sexton, Fuqua Springs, N. C.
Oscar Stansbury, Chico, Cal.
Frank A. Warner, Baltimore, Md.
Randolph Winslow, Baltimore, Md.

Major William F. Lewis, class of 1893, Medical Corps, U. S. A., who has recently returned from the Philippine Islands, and who has been spending a leave of absence in North Carolina, was in Washington recently en route to his station, Presidio of Monterey, California.

Dr. G. Timberlake read a paper before the recent meeting of the West Virginia Medical Society, September 20, 21 and 22, at White Sulphur Springs, W. Va.

Capt. Frank Watkins Weed, class of 1903, Medical Corps, U. S. A., has been ordered to proceed to Manila, P. I., on the transport sailing from San Francisco on or about February 5, 1912, and on arrival will report in person to the commanding general, Philippine Division, for assignment to duty.

Dr. Charles Thomas Harper, class of 1894, who is medical director and owner of the Wilmington Sanitarium, corner Front and Castle streets, Wilmington, N. C., writes in reference to his sanitarium: "I am thankful to say I have met with more than success since its opening. I have 15 beds, five nurses and an orderly, and have done some very satisfactory work. It is open to the profession, and a few have taken advantage of the pleasant surroundings. I wish to thank Dr. Randolph Winslow and the staff of the University Hospital for the courtesies while there, and assure them I will call again."

Dr. Harper's reputation is general in both North Carolina and Maryland, and his acquaintance with professional men extends throughout the South. He was born at Smithville, N. C., August 10, 1872, the son of James Thomas and Annie S. (Drew) Harper, both of North Carolina, and descendants of American ancestors. His earlier education was obtained in the public schools of Smithville and at Cape Fear Academy at Wilmington, and his collegiate education at Trinity and Davidson colleges. He afterwards entered the University of Maryland, from whence he graduated in 1894. He was interne at the University Hospital during his last year at the University, and afterwards practiced for four years in Baltimore. He was at that time connected with the teaching force of both the Baltimore University Medical College (now extinct) and the University of Maryland. He left Baltimore in 1898, and took up his residence in Wilmington, where he has become well known. Since 1900 he has been superintendent of public health of Wilmington. He is a member of the North Carolina State Medical Society, the Hanover County Medical Society and belongs to several fraternal orders, including the Masonic and Knights of Pythias. He is president of the Boney & Harper Milling Co. We wish Dr. Harper much success with his sanitarium.

Miss Henrietta Ashcom Gourley, University Hospital Training School for Nurses, class of 1908, has returned to her former residence, 2128 St. Paul street. We are glad to report that Miss Gourley has sufficiently recovered her health to resume her practice.

Dr. Samuel A. Stevens, class of 1900, of Mon-

roe, N. C., was a recent visitor to the University Hospital.

Dr. Page Edmunds, class of 1898, has removed to the Wentworth Apartments, Mulberry and Cathedral streets, Baltimore.

Dr. Edmunds, since his graduation, has been very successfully engaged in the practice of his specialty—genito-urinary diseases—in Baltimore, and has been continuously associated with the staff of the University Hospital. He is at present associate in genito-urinary diseases. In 1907 he was appointed surgeon to the Baltimore & Ohio Railroad, and in 1909 consulting surgeon to the same road. He is also surgeon to the Washington, Baltimore & Annapolis Railroad. He did post-graduate work in Berlin in 1904. Dr. Edmunds is the son of Dr. Page Edmunds and Susan Elizabeth (Cowart) Edmunds, and was married to Miss Millicent Geare, class of 1905, University Training School for Nurses, in St. Ann's Church, Annapolis, Md., May 30, 1907.

Dr. Joseph E. Gichner, class of 1890, has returned from a visit to Germany. This is his first visit there since he did post-graduate work at the University of Berlin 20 years ago. While Dr. Gichner was abroad he met Dr. Ehrlich, the discoverer of "606." He was extremely interested in the Hygiene Exhibition, which was in session from May 1 to October 1, and draws the following pen picture of it for the Evening *Sun* in a recent interview:

"A spot as large as Druid Hill Park, occupied by many buildings, in which there were shown in such popular manner as to inform even the ignorant classes of the progress which has been made in medicine and its allied sciences in knowledge of clean living as related to health; Europe, Asia, Africa and South America contributing.

"The United States," said Dr. Gichner, "was the only one of the family of nations which did not have an exhibition there. That points again to the need of a national department of health in our country. It is preposterous to think of the nation whose physicians made possible the building of the Panama Canal when other nations had failed because they could not master the problems of health involved in the project, whose physicians stamped out yellow fever in Cuba and did so much to rid the Philippines of disease, failing to exhibit at such a world-congress as that at Dresden.

"The museums and laboratories of the universities of the world were searched for the material for this exhibition. Imagine a place in which one may wander from a room in which one sees illustrated the bearing of objects of Egyptian daily life and the ceremonies of burial on the health of that ancient people, to another room in which is depicted the sources of the pestilences of the Middle Ages and the measures which were used to fight them; and then on to other rooms in which cuts of diseased meat are displayed, in which the modern housewife is shown how to detect these diseases on the market stall, in which she is shown how to cook and dress a joint of beef in order to get the greatest food value from it! The relations of clothing, housing and of occupations to health were shown in equally graphic manner. Superstitions in regard to disease, the belief that amulets and charms would ward off ailments, were ridiculed in the exhibits in a manner which could not fail to impress the people.

"The temperance question was not neglected. There is in Germany a distinct tendency to curb the drinking habits of the students and the people in general. There are many temperance societies in the empire, as there are here, but many are merely temperance, not total abstinence, societies. The effects of alcohol on the human body were shown."

Dr. James Hugh Bay, class of 1908, has been appointed by the Postoffice Department as examining physician to the Civil Service Board of Examiners for Havre de Grace, Md.

Dr. J. Francis Byrne, class of 1910, is connected with the experimental department of Parke, Davis & Co., and is residing at 1324 McCulloh street.

Dr. Richard C. Dodson, class of 1911, is located at the Atlantic Coast Line Hospital, Waycross, Ga.

Dr. Arnold Dwight Tuttle, class of 1906, is located at the Army General Hospital, San Francisco, Cal.

Dr. O. S. Gribble, class of 1904, is located at Beverly, W. Va.

Dr. Charles W. McElfresh, class of 1889, has removed to the Cleveland, 1415 Linden avenue, Baltimore.

Amongst our alumni located in Georgia are the following:

J. L. Riley, '05, 29½ Marietta avenue, Atlanta.

Herbert Jerome Rosenberg, '08, Henry W. Grady Memorial Hospital, Atlanta.

Julian P. Harrell, '06, 713 Egmont street, Brunswick.

Edgar B. Davis, '04, Byromville.

William A. Chapman, '87, Main street, Cedartown.

James H. McDuffie, '87, 1206 Second avenue, Columbus.

Wm. Benjamin Warthen, '05, Davisboro.

Harlan L. Erwin, '04, Spencer street, Dalton.

Nathaniel L. Spengler, '03, Donaldsonville.

Chas. Wesley Roberts, '06, Douglass.

Joshua B. Walker, '90, Dudley.

Edwin J. Dorminy, '90, Fitzgerald.

Henry Latimer Rudolph, '02, 44 N. Greene street, Gainesville.

Virgil E. Franklin, '96, Graymont.

H. J. Erwin, '04, Hamilton.

Elijah S. Peacock, '91, Harrison.

Samuel T. R. Revell, '05, Broad street, Louisville.

Jefferson D. Wright, '82, Broad street, Louisville.

Jos. W. DuGuid, '93, 519 Forsyth street, Macon.

Weenes R. Winchester, '74, 610 Mulberry street, Macon.

J. D. Malone, '84, Malone Building, Marietta.

Samuel S. Gaulden, '86, Walker Building, Quitman.

J. A. Bussell, '88, Rochelle.

Chas. D. McRae, '88, Rochelle.

Wm. Rawlings, '75, Sandersville.

Craig Barrow, 1900, 26 Liberty street, Savannah.

Raymond V. Harris, '07, Savannah.

S. Latimer Phillips, '85, 232 Bull street, Savannah.

Harry Young Righton, Jr., '07, 12 Jones street W., Savannah.

F. A. Blackwell, '05, Tignall.

Dr. William Dodds Scott, Jr., class of 1904, who has been engaged in Baltimore in the practice of genito-urinary diseases since his graduation, has removed to Cambridge, Md., where he will enter general practice. Dr. Scott was prominent in his student days as an athlete, and was very much beloved by the student body. For one year after graduation he occupied the position of assistant resident surgeon in the University Hospital, since which time he has been connected with the Genito-urinary Department of the University of Maryland, at the time of his resignation holding the position of associate in this department. For the past 18 months Dr. Scott has been connected with the Dispensary force of the Johns Hopkins Hospital in the Department of Genito-urinary Diseases. The BULLETIN joins his many friends in wishing him much success in his new field.

Miss Frances Robey, member of one of the first classes to be graduated from the University Hospital Training School for Nurses, is ill with typhoid fever.

BIRTHS

Dr. Robert L. Mitchell, class of 1905, and Mrs. Mitchell, 2112 Maryland avenue, have announced the birth of a son, Robert Levis Mitchell, Jr.

MARRIAGES

Dr. Frederick Henry Herrman, class of 1907, of 3115 East Baltimore street, and Miss Minnie Heed, daughter of Mr. and Mrs. Charles Heed, of 16 South Patterson Park avenue, were married on Tuesday, October 3, at Alexandria, Va., by Rev. George F. Hyde. Dr. Herrman and Miss Heed first met five years ago when members of the same Sunday-school. They were accompanied on the trip to Alexandria by Mr. and Mrs. Rennenberg, a brother-in-law and sister of the bride. The honeymoon was spent in New York, and a reception was given the bride and groom upon their return to Baltimore, October 7, at the home of the groom's parents. Dr. Herrman spent six months after graduation as assistant surgeon in the Hebrew Hospital. He is well known in East Baltimore.

Dr. Benjamin Robert Benson, Jr., class of 1907, of Cockeysville, Baltimore county, Mary-

land, was married to Miss Elsie Bartleson, daughter of Mr. and Mrs. Hilberd E. Bartleson of Cockeysville, on Tuesday afternoon, October 10, 1911, at 3 o'clock, at the Sherwood Protestant Episcopal Church. The couple will be at home after November 1.

Dr. Arthur Blake Clarke, class of 1906, of Plantersville, S. C., and Miss Mary A. Bath, also of Plantersville, were married in Charleston, S. C., on Tuesday afternoon, August 22, by the Rev. W. H. Murray. Dr. Clarke is a native of Canada. Since entering upon practice in South Carolina he has built up a fine practice and reputation in the section where he makes his home. He is regarded as a physician of brilliant attainments.

DEATHS

It is with the deepest regret that we announce the death of Mrs. Minna Howison Coale, wife of Dr. R. Dorsey Coale, dean of the Medical Department of the University of Maryland.

Mrs. Coale was operated on for appendicitis on Monday last at the University Hospital, and at first the operation was thought to be successful, but Mrs. Coale died on Friday, October 6, 1911, at 6 P. M., of heart failure.

She was the daughter of the late Capt. John W. Howison of the United States Revenue Cutter Service, and was born in New Bedford, Mass., 37 years ago. She came to this city with her parents when quite a small child, and was educated at Notre Dame. She met Dr. Coale while visiting her uncle, Dr. Rohe, while still a pupil at Notre Dame. She was a descendant of the Coffins of Nantucket, one of the oldest and most prominent families of New England. She is survived by her mother, Mrs. J. W. Howison, and one sister, Mrs. Leslie Witherspoon of Chicago.

Mrs. Coale was a woman of engaging personality, and beloved by all who were so fortunate as to know her. She was an expert horsewoman and was frequently seen on the many drives around Baltimore. She was a member of the Colonial Dames, and was prominent socially. She was considered one of the most beautiful women in Baltimore, and will be much missed in many circles in Baltimore.

Mrs. Coale was buried from her home, 17 West Mt. Royal avenue, Monday afternoon, October 9, 1911. Only the members of the family and a few close friends were present. Rev. William A. McClenthen of Mt. Calvary Protestant Episcopal Church, conducted the services. Burial was in Greenmount Cemetery. Out of respect to Mrs. Coale's memory, lectures were suspended in the Medical Department of the University the day of the funeral.

As we go to press we learn of the death of Dr. John Reese Uhler, class of 1861, of 1531 McCulloh street, Baltimore, after an illness of two years.

Dr. William Worthington Hopkins, class of 1858, died at his home, Gover's Hill, near Havre de Grace, Md., August 4, 1911, after a prolonged illness. He was the son of the late Dr. Thomas C. Hopkins, class of 1830. Dr. Hopkins was well known and much beloved all through Harford county. He was buried on August 6 from Grace Protestant Episcopal Church, Darlington, Md., interment being in Darlington Cemetery. He is survived by his widow, who was critically ill at the time of his death, and a son and daughter.

Dr. Joel W. Nixon, class of 1878, died suddenly at his home, 5455 Page avenue, St. Louis, Mo., on August 25, 1911.

Dr. Joseph Penn Chaney, class of 1852, died recently at his home at Breathedsville, Washington county, Maryland, aged 81 years. Dr. Chaney was educated at Marshall College, Mercersburg, Pa., and at the University of Maryland. The Chaney family is of French origin, and went to England with William the Conqueror. Dr. Chaney began the practice of medicine in Funkstown, and later removed to Breathedsville. He retired in 1890, and since has devoted his time to farming. His wife was Miss Maria Van Lear, a granddaughter of Major Van Lear, a member of General Washington's staff. She died eight years ago. He is survived by two sons—Bartholomew V. L. and Eastburn Chaney, and four daughters—Mrs. Harvey Dillenger of Williamsport, Md., and Misses Eno, Sadie and Minna Chaney.

Miss Gray, a pupil nurse in the University Hospital Training School for Nurses, died at the

University Hospital September 13, 1911, from typhoid fever.

Dr. Luther M. Zimmerman, class of 1864, a well-known physician and druggist of Hagerstown, Md., died at his home, 699 S. Potomac street, Wednesday, September 13, 1911, after a prolonged illness, aged about 70 years. Dr. Zimmerman was born near Woodsboro, Md. He was educated at Pennsylvania College, Gettysburg, Pa., and also graduated from the medical department of the University of Maryland. He served as surgeon in the Union Hospital at New Orleans for six months during the Civil War. He practiced medicine at Westminster, Johnsville and Meyersville, remaining at the latter place about 30 years. In 1898 he moved to Hagerstown, and in addition to his practice opened a drug store. He practiced until about a year ago, when, owing to physical disability, he gave up both his practice and drug store.

Dr. Zimmerman was a member of St. John's Lutheran Church, and until a year ago taught a class in the Sunday-school connected with this church. He was a life-long Republican, and for a number of years served as postmaster at Meyersville. He was buried on the Friday following his death in the family lot at Woodsboro. He is survived by a widow and five children, the latter being Rev. H. E. Zimmerman, New Haven, W. Va.; H. C. Zimmerman, Philadelphia; Mrs. W. R. Harp, Hagerstown,; Miss Cora and Miss Edith Zimmerman, at home.

LABORATORY REPORT OF THE UNIVERSITY HOSPITAL.

Month of August.

Blood Examinations.

Leucocyte counts	167
Erythrocyte counts	37
Differential leucocyte counts	14
Hemoglobin determinations	68
Smears for malarial parasites	13
Blood cultures	10
Wasserman	14
Widals	89
	412

Urine Examinations.

Routine urinalysis (chemical and microscopic)	341
	341

Miscellaneous.

Gastric contents (chemical and microscopic)	15
Feces (macroscopic, microscopic and some cases chemical examination)	10
Sputum examination	25
Bacteriological cultures and smears	24
Examination of ascitic fluid	2
Sections of tissue for microscopical examination	25
	101
Total	854

Month of September.

Blood Examinations.

Leucocyte counts	210
Erythrocyte counts	68
Differential leucocyte counts	20
Hemoglobin determinations	80
Coagulation time	2
Smears for malarial parasites	30
Blood culture	5
Widals	83
Wasserman	18
	516

Urine Examinations.

Routine urinalysis (chemical and microscopic)	380
Total estimation for chloride	1
Total estimation for urea	1
	382

Miscellaneous.

Gastric contents (chemical and microscopic)	18
Feces, etc.	6
Sputum examination	22
Bacteriological cultures and smears	28
Vaccines	4
Examination of spinal fluid	1
Examination of hydrocele fluid	1
Sections of tissue for microscopical examination	17
Autopsies	1
	98
Total	996

Dr. J. L. Hirsh,
Dr. H. J. Maldeis,
Dr. L. K. Walker,
A. G. Martin,
J. D. Sharp.

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A HURRIED TRIP THROUGH EUROPE.

By T. A. Ashby, M.D.

(*Continued from October 15th Issue.*)

On our arrival in Interlaken at 9.30 P. M. o'clock we found pleasant rooms in the Royal St. George Hotel. After a continuous ride of 13 hours from Paris, it seems needless to say, we were both tired and hungry. A good supper quickened our energies and gave us a spirit for sightseeing. We started out on foot to see the city, brilliantly illuminated with electricity and alive with crowds of people visiting the cafés, parks and casinos. Bands of music were giving outdoor concerts, various places of amusement were open to inspection, and a merry crowd of men, women and children was promenading the streets or seated around tables enjoying refreshments and drinks.

The place was filled with tourists and summer visitors, all bent upon sightseeing and pleasure. For over two hours we took in all that could be seen during that time and then returned to our rooms for a night's rest. When I arose from my bed the following morning, the first objects my eyes met were the tall peaks of the Jungfrau, covered with snow, seventeen miles distant, towering over 13,000 feet into the heavens. This view from the window of my room was the most beautiful and impressive I have ever witnessed. The snow-capped mountains all around were in striking contrast with the green fields and growing crops in the valleys below. The temperature in Interlaken during our stay there was uncomfortably warm, whilst in the higher altitudes into which the peaks of the Alps reached we had a perfect object lesson of summer and winter temperature in close proximity.

After breakfast Mr. Page and I took a victoria and were driven all over the city and surrounding suburbs. Interlaken is situated in a level valley surrounded almost entirely by lofty mountains. It is located on the banks of a rapid and bold stream of water which carries the waters of Lake Brientz into Lake Thun, the distance between the two lakes being about one mile. The main street of the city runs parallel with the river the entire distance, whilst the large hotels and casinos face on the street, with large parks and grounds extending back to the river. Other sections of the street are lined with ponceons, stores, bazars and eating-houses. The hotels are large and beautiful structures and give accommodations to large numbers of tourists and summer guests. In fact, the residential population is very small during the winter months and the place is almost abandoned. During the summer season thousands of people flock to the place and the hotels, ponceons and boarding houses are filled with visitors from all parts of the world, who come to see the lake and mountain scenery and to enjoy the pleasant summer climate. Everything is done to attract and entertain the visitor. I saw no attempts to impose upon one and was struck with the very moderate prices of living and with the courtesy of those who had goods to sell. I made a number of small purchases and found prices lower than in other cities in Europe.

In the afternoon we took a funiculaire, a small car draw by cable, and were lifted up a high mountain some five thousand feet to a summer café, known as Harder Kulm. From this point the view was magnificant, a perfect panorama of mountain, valley, lake and city was spread before the eye, giving a picture of such rare and extended view as to crowd the mind with awe and admiration. Nature and art seemed to be holding truce, and contending for supremacy. It

would be difficult to say whether the wildness and grandeur of nature improved by the art of man would have been more impressive without artificial aid, or whether the effect had been so enhanced by human effort as to make the whole a more perfect picture. This beautiful Alpine scenery owes so much to the toil and ingenuity of man that one is carried away by the effect. Magnificent roads and drives, beautiful villas and hotels on lofty plateaus and mountain peaks, steep mountain sides cleared of timber and green with pastures, fields of growing crops, lakes with steamers and sailboats, railroads and cars running through valleys or canyons, or over the highest mountain passes, all demonstrated the power of man to subdue nature and improve upon her works.

I am inclined to think that the great beauty of Alpine scenery is made more noticeable by the decorations which man has given to it. Take away from this scenery the background which the roadways, railways, bridges, cities, villages and cultivated lands give to it, and we find that we have in Canada, Alaska, and in some of our Western States, mountains higher and grander than any in Switzerland; glaciers and ice-fields that will dwarf anything in Europe. In this country everything is in the wild; man has done nothing to bring these great natural wonders into general notice or to make them accessible to the average traveler.

On Sunday afternoon we took a railway train which carried us some 17 miles through narrow and deep canyons to the foot of the Jungfrau. Leaving the car we entered a funiculaire, and were lifted some 5000 feet to a plateau on the mountain, where we again took an electric road which wound round the mountain side the distance of a mile to a summer resort known as Mürren. This place is separated by a canyon from the Jungfrau, one mile distant, with her peaks white with snow, now standing out and reaching up over 13,000 feet. The view of the Jungfrau was grand and inspiring. It was well worth the long and dangerous climb we had to see it. Whilst standing in the depot at Mürren I met several ladies who lived next door to my home in Baltimore. They were resting for the summer in one of the hotels at Mürren. I am sure we were mutually happy over such an unexpected meeting. We had also the good fortune to meet several Baltimore friends who were boarding in Interlaken. I know of no pleasure so satisfactory as to run across one's friends in a foreign country.

We took a steamer Monday morning at Interlaken and were carried across lake Brientz to the landing, some 10 miles distant. Here we again took the cars and were carried over high mountain rages to Lucerne. The ascent of the mountains was so steep that the locomotive was compelled to use a cogwheel and third rail to climb up the grade. Progress was so slow that it took nine hours to go from Interlaken to Lucerne, a distance of some thirty miles. The view of the country through which we passed fully compensated us for the tediousness of travel. High mountains, valleys, lakes and bold streams of running water all subdued and utilized by man, made a picture of great beauty to the tourist. Everywhere the landscape was dotted with towns, villas, factories, farmhouses, hotels and cultivated fields. Almost every acre of ground seemed to be used for the service of man, so diligently have the people of Switzerland improved their lands and homes.

We reached Lucerne at 6 o'clock in the afternoon and found accommodations at the Hotel Victoria. As soon as we could wash up and make a few changes in our clothes we secured a cab and started out to see the city before dusk. A drive of some two hours gave a fairly good view of the city. Among the many curiosities of Lucerne is an old tower, situated at the point where the River Reuss issues from the Lake of Lucerne, which is said to have been a lighthouse in Roman times, and hence gave the name to the town. We also saw the celebrated Lion of Lucerne, hewn out of the solid rock by Thorwaldsen, a monument to the Swiss Guard which perished at the Tuilleries in 1792. Lucerne is a place of some 35,000 resident population, which is more than doubled during the summer season by visitors and tourists. It contains many large and handsome hotels, which were filled at the time of our visit. These hotels, for the most part, are located on the lake front and are surrounded with handsome parks, drives, and walks. After dark these places were brilliantly illuminated and thousands of people were parading along the walks and lake front. The hotels were also filled with handsomely dressed men and women, the representatives of numerous nationalities. Large rooms were filled with roulette tables and other

gaming devices, where men and women were betting heavily on the fall of the cards or the turns of the wheel. The excited crowd was so intent upon the chances of fortune and stood so packed around the tables that the looker-on had few opportunities to observe the result of the games. I was surprised to see so many handsomely dressed women at these gambling tables. They seemed to outnumber the men and were bold bettors. Is this an indication of the rôle the modern and up-to-date woman is going to assume when woman suffrage becomes universal? Does not the commercial spirit tend to lower rather than to elevate the standard of womanhood? If women are to become competitors of men in all lines of barter and trade, in vote-getting and office-holding, in the government of municipalities and States, is there any less reason to expect her as a competitor in gaming and horse-racing? These are practical questions which all thinking and self-respecting women should ask themselves. We know the innate depravity of man, his love of hazard and chance, his downward tendencies, and have in the past depended largely upon the purity and righteousness of womanhood to correct his errors. If his best guide and helpmate is going to compete with him in his lower vices, what help is there for a better social life and race development?

Lucerne is certainly a most beautiful city, a great summer resort for the rich and the gay, for the upper strata of society where wealth and display have full sway. A stay over night was enough to satisfy our curiosity. We left at 8 o'clock Tuesday morning for a tour down the Rhine. We traveled by rail from Lucerne to Basle, where a change of cars was made. From Basle we went to Maintz, on the Rhine, where the night was spent. The all-day ride from Lucerne to Maintz was through Swiss and German territory. The day was exceedingly warm and the country was so dry and parched that we have no pleasant recollections of this part of our trip. I saw little in the farm lands or in the towns and cities through which we passed to create good impressions. After reaching Maintz we stopped at the Rheinländer Hof, which faces a broad avenue on the bank of the Rhine. In the evening we visited a large park near the hotel, which was filled with small tables and chairs occupied by several thousand people—men, women and children—all seated around the tables drinking beer, wine, soft drinks, and many taking an evening meal. A band in a large covered stand was rendering operatic music of a very high order. In fact, the music was about the best we heard in Europe. These people were very happy and well-behaved, representing the middle and higher classes of society. They were eating, drinking and making merry with laughter and clapping of hands over the performances of the band. This, I understood, was a fair example of the evening life of the German people. There was nothing immoral or vulgar in the crowd, but a suggestion of a refined, amiable and cultivated people.

On Wednesday morning at 9 o'clock we went aboard a large steamer for a day's ride down the Rhine. The steamer was loaded with passengers representing many different countries and languages, all, like ourselves, tourists bent on sight-seeing. The day was clear and the temperature moderate, so that everything seemed propitious for an enjoyable passage down this historic river. The Rhine, as all must know, has its sources in the mountain snows of Switzerland. These melted snows pour down into the Swiss Lakes, which act as huge reservoirs connected by running streams until they unite to form the Rhine. The river then flows north through Swiss and German territory until it reaches the lowlands of Holland, where its course is diverted westward by north until it empties through numerous channels into the German Ocean.

The volume of water is enormous, and its variations are very slight. Where we took the boat at Maintz the river is some 600 yards wide, and its depth sufficient for large vessels drawing from 10 to 12 feet. The current, I should judge, averages from four to six miles an hour, and at several places was much more rapid. The Rhine at Maintz is about the same size as the Mississippi at St. Louis at mean water gauge, but differing from the latter in the clearness and purity of its waters. Since the time of Julius Caesar the Rhine has figured more largely in history than any of the rivers of the world, not excepting the Nile. It has been written up in song and story, in romance and history, in war and conquest, and in all the arts of husbandry and social life. Its vine-clad hills and ruined castles bear witness to its present prosperity and to its departed glory. As a route of travel, as an avenue of commerce, its waters today bear more people and more freight than any river of its length in the world.

A ride down the Rhine is, therefore, a pleasure greatly sought, and an enjoyment which one must experience to fully appreciate. The banks of the river from Maintz to Cologne are lined with riprap, stone or concrete walls. There are no trees on banks to obstruct the view, but the farmlands, villas, towns and cities are in full display, giving an endless variety of scenery and beautiful sights. The upper portion of the river passes through a level and gently rolling landscape; many beautiful villas and private residences, splendid farmlands and vineyards line both banks. When Bingen is reached the river winds its way through high, towering mountain peaks, with sides covered with terraced vineyards and tops crowned with the ruins of ancient castles.

Bingen has been immortalized by the beautiful poem of Mrs. Norton. Many will recall the story of the soldier dying in Algiers, who said to his companion:

"Take a message and a token to some distant friends of mine,
For I was born at Bingen, at Bingen on the Rhine."

The many ruins of ancient castles standing as lonely sentinels overlooking the river recall the times when feudal lords and robber barons held possession of this country and ruled with blood and terror. As these old relics of a barbarous age came into view, I could not help contrast our peaceful ride down the river with the days long gone by, when war and pillage made these old ruins the only safeguard against savage and brutal man. Could they but speak, what a story of strife and beastly passion would be related to the present tourist!

I was surprised at the extent of the commerce of the river. Every few minutes we were passing tugs pulling large barges loaded with coal, timber and other articles of freight. Both banks of the river were lined with double-track railroads, which were kept busy with long trains of cars carrying freight and passengers up and down the stream. There was a bustle and activity both on land and water which one never sees on the waterways of our country.

We arrived at Cologne at 5 o'clock in the afternoon, having been some nine hours on the Rhine, the distance covered being some hundred miles. After landing we were driven to the Hotel Dom, where comfortable rooms were secured. This hotel is located on the square just across the street from the Cathedral. This gave us the best opportunity to see and study the proportions and design of this great work of art, a structure of such collossal size and architectural ornamentation that it stands among the great Cathedrals of the world, if not in the first place. Notre Dame, in Paris, and the Cathedral in Milan are generally regarded as its chief rivals.

The chief attraction in the Cathedral in Cologne is its antiquity and the richness of its carvings, ornamentations and artistic finish. As a work of art, it deserves the first place, as its symmetry, classic design, richness in decoration and statuary are marvels of architectural skill and labor.

The first Cologne Cathedral was located on the site of the present Cathedral in the ninth century by Hildebold, and was completed under Willibert in 873. This building was destroyed by the Normans, but was later rebuilt, and Willibert was buried in its walls. Over three centuries later the Cathedral was destroyed by fire. In 1248 the foundation stone of the present edifice was again laid, but it was not until 1322 that the choir was consecrated. After another century, 1437, the southern tower was so far completed that bells could be hung. From this time on the progress of the building was not only suspended, but its beauties were often destroyed during the wars in which Germany was engaged. In 1816, under the patronage of Frederic William III, a review of the plans and reconstruction of the Cathedral took place, which led to the final completion of the present edifice in 1880. Centuries of time and vast sums of money have been used in the construction of this great monument of architectural skill. Like most churches built in the middle ages, the Cathedral is a cruciform structure, composed of a nave, flanked with double aisles and a transcept with single aisles. The two outer aisles do not extend the entire length, but terminate at the choir, and receive their continuation in numerous chapels surrounding the choir. The great beauty and grandeur are derived from the towers of four stories, with crowning spires reaching a height of 507 feet. In these towers and spires are hung the great bells. The soft and sweet notes from the great bells are heard at frequent intervals during the day. In the early morning I was aroused from sleep by the music of the Cathedral bells, and never in my life have

I heard such sweet sounds. They still ring in my ears. I feel that I would be willing to make another visit to Cologne to hear the ringing of its great bells, so deep and lasting is the impression made on my mind.

During our short stay in Cologne we again made use of the cab to see the city. We rode through its great streets and avenues and saw many of its public buildings and private residences. It certainly is a very beautiful place, and for its size compares with Paris, London and Berlin in its architecture, streets and business enterprises. Cologne has about the same population as Baltimore, but it will take the latter city many years to catch up with Cologne in good streets, in handsome buildings and in business enterprises and thrift.

I was greatly impressed with the enormous steel bridge crowning the Rhine at Cologne. I should say that it is larger than any of the bridges expanding the Mississippi at St. Louis and as large and imposing as the great bridge connecting New York and Brooklyn.

We left Cologne at 3 o'clock Thursday afternoon for Brussels, arriving at the latter place at 7 o'clock. The ride through that part of Germany and Belgium did not create much enthusiasm. The country is rolling, and in places rough, not in high state of cultivation and lacking in general attractiveness. As we came near to Brussels the farmlands were neater in appearance and were better cultivated. The Dutch farmhouses and outbuildings assumed the character of the Dutch farmer. They were neat and old-fashioned, ugly and crude. The windmill came in evidence as a motive power, and seemed to be doing work when the wind was blowing.

Brussels was brilliantly lighted when we stepped from the car to the depot. We were driven to the Hotel Metropole, where we found good accommodations. After a substantial dinner we walked around the city for several hours and had a fair view of the business sections.

Brussels is better known to Americans as a place where carpets and laces are manufactured. In history it is better known as the great capital of the Dutch Republic and as the battleground where religious liberty had its birth and first great triumph. Of the modern city I shall have little to say. Of its history and people much can be said to interest every student and thoughtful person interested in the growth of civilization and an observer of the progress which man has made in political and social government. The vast plain of lowlands extending from the Ural Mountains to the German Ocean is occupied by the countries once called the Netherlands, now known as Belgium and Holland. This country is surrounded by France, Germany and the ocean. This low country has been cut into numerous sections by the rivers Rhine, Meuse and Scheld, which for ages have deposited the debris brought down from the highlands among the sand banks thrown up by the ocean around their mouths. By dikes and canals the inhabitants of these low countries have redeemed from the ocean and estuaries of these rivers much of the land now making Holland and the lower parts of Belgium. Here we have the best illustration of the thrift and industry of man in land building, in home building, in government building and in all the arts of commerce and trade. The first notice we have of these people, whose descendants now make the great Dutch nations, is given by Julius Caesar. In his time hordes of savages lived in the swamps and thickets, now the richest agricultural section of the world. Under the Romans the native tribes were held in subjection for several centuries. They were a brave and high-spirited race, and for the next fourteen or fifteen centuries were contending among themselves and with neighboring races for freedom and liberty of conscience.

Ethnographically, the peopie of these low countries belong both to Gaul and Germany. In the centuries which have passed the Gallic and Teutonic blood has so mixed that the Dutch race has been evolved, a race so distinct intellectually, morally and physically as to give it a racial standing among the great nations of the world. The steps by which these Dutch people have climbed into the front rank of civilization illustrate their high order of intelligence and moral force. They have had in all the centuries past a love for liberty and self-government, a hatred of tyranny and oppression. These passions have dominated every action and have led to many wars and revolts. The Netherlands have been ruled by the Franks under Charlemagne, by the Austrians under Maximilian, by the Dukes of Burgundy under Philip the Good, Charles the Bold and Philip the Fair, and by Spain under Charles the Fifth and Philip the Second. Whilst nominally governed by foreign rulers they grew in wealth and population,

and early became the richest and most cultivated people of Europe. By industry and thrift they built up large and beautiful cities, opened up a commerce which carried their manufactured products to every part of the known world and established prosperous colonies among distant peoples. These Dutch people early recognized the advantages of education and moral culture. Their schools and universities were amongst the best in Europe; their artists rivaled those of the best Italian schools and surpassed the other nations. When the doctrines of Protestantism under Luther spread over Northern Germany, the Dutch people were among the first to absorb the principles of religious freedom and toleration which these doctrines maintained. In the German Reformation the people of the Netherlands experienced all the hardships and persecutions that Catholic Spain could impose upon them. Under Charles the Fifth and Philip the Second the Spanish Inquisition was introduced, and the heretics were punished with merciless cruelty. No mercy was shown to those who claimed the right of freedom of conscience or of religious toleration. Margaret of Parma, daughter of Charles the Fifth, as Regent of the Netherlands, made every effort to down the heretic and to suppress the Protestant movement rapidly growing under the persecutions of the Inquisition. After her removal the Duke of Alva succeeded to the Regency. The cruelty of this monster and bigot has made his name the most detested among all men and all times. He ruled with such vengeance that even his Catholic subjects, opposed to the Inquisition, but loyal to their church, were executed on the slightest evidence. Among the Catholic noblemen in the Netherlands who countenanced moderation and resisted the Inquisition three great characters stand out in history—William, Prince of Orange, Count Egmont and Count Horn. The two latter were executed by Alva on the ground that they had opposed the Inquisition and had given encouragement to heresy. Count Egmont was the hero of St. Quentin and Gravelines, and as commander of the Spanish armies had won the two greatest victories ever won by Spain over the French. He was one of the most popular men of his day; his services to the country had been eminent. He stood with his people for freedom of conscience. This was too much for Philip and Alva. He and Horn were judicially murdered by decapitation in the park fronting the palace in Brussels. The people of Brussels have erected bronze monuments to these two patriots, which stand in the park near the place of the execution.

William, Prince of Orange, generally known as William the Silent, was a young nobleman of great talent and purity of character. He enjoyed the love and esteem of Charles the Fifth, which gave him great influence in the government of the Netherlands under Margaret. He opposed the Inquisition, and did all that was possible to arrest its work. He saw what was coming, and retired to Germany when Alva was made regent. In this way he escaped the fate of Egmont and Horn. William of Orange now became the great leader of the revolt against Spain. Under his master hand the Dutch Republic was molded into shape, and the Netherland people were liberated from Spanish rule. The history of the Dutch Republic is a history of war and bloodshed, of fierce struggle and contest for a single principle—the right of man to worship his Maker after the dictates of his own conscience. This principle, so bitterly contested, was established by the courage and patriotism of the Dutch people, to whom the world owes a debt which cannot be too highly appreciated. The wonderful wealth and prosperity of the people of Belgium and Holland can be attributed to their industry, thrift and love of freedom. These two small kingdoms, surrounded by the great powers of Europe, have built up many large and beautiful cities; have established prosperous colonies in distant countries, and carry on a commerce that it a marvel even to larger nations. No section of the world is so densely populated as these two kingdoms, and perhaps no people enjoy greater freedom and prosperity.

After spending two nights and one day in Brussels we left Saturday morning for Hague.

(*To be continued.*)

In our biography of Dr. Walter Henry O'Neal, class of 1871, of Gettysburg, Pa., published in the September, 1911, BULLETIN, we neglected to state that Dr. O'Neal was the secretary member of the United States Pension Examining Board for Adams county during the administration of the late President Cleveland. At present he is a member of the National Geographic Society and director of the Gettysburg National Bank.

Dr. Claude C. Smink, class of 1909, is located at Lauraville, Md.

SEE AMERICA FIRST.

By Randolph Winslow.

3. THE YOSEMITE VALLEY.

The itinerary of our special train demanded that we leave Los Angeles on Friday, June 30, at 4 P. M., and consequently we had to forego certain festivities at Pasadena and elsewhere that we would have been pleased to have participated in; in fact, we would have been pleased to have lingered longer in Los Angeles, and to have explored the many attractions of that city and its environs. At the appointed time, therefore, our company met at the Southern Pacific station and entrained for the Yosemite Valley, which is one of the National parks of the country, controlled by the Government and guarded by United States cavalrymen. We had hardly gotten well settled on the train when we were informed that an explosion of dynamite had occurred, wrecking a freight train and blocking the direct route, and that it would be necessary to make a 90-mile detour in order to proceed on our journey. This brought us to Oxnard, where there is an enormous beet sugar factory, and through a region where beets are the chief object of cultivation, and thence through lemon groves back to the main line. It is quite a step from Los Angeles to the Yosemite, and we were more than 24 hours in reaching our destination.

At Merced we transferred to the Yosemite Valley Railroad and ran up the wild Merced Valley, with its rushing river and beautiful scenery, to El Portal, at the entrance to the park. Here we took busses and were driven 14 or 15 miles over a narrow and dusty road to the Sentinel Hotel, or, if one prefers, to one of the tent villages that are established in the valley. The Yosemite Valley is a deep cleft in the heart of the Sierras, about seven miles in length and three-quarters of a mile wide; its floor is level and covered with beautiful trees, and through its center the ice-cold Merced River rushes on its rollicking way. The valley is bounded by sheer walls of riven rock, cleft by some mighty cataclysm and rearing their barren sides from three-quarters of a mile to a mile in the air. These grim and apparently unconquerable barriers are carved into many fantastic shapes, forming arches, domes, half domes, pinnacles and spires, while from the rim of the mountain wall tumble with a roar and rumble numerous waterfalls to the bottom of the valley hundreds, and in some instances, thousands, of feet below. There is perhaps no other place of equal size on the face of the earth where there are so many stupendous cataracts; indeed, it it stated that nowhere else can waterfalls of equal height be found. The Yosemite Falls are 2630 feet high, but the descent is not absolutely unbroken, though its impact is sufficient to shake the earth and to cause a rain of spray to sprinkle the surrounding area for a considerable distance, and to produce luxuriant and verdant vegetation. The Bridal

NEVADA FALLS, YOSEMITE VALLEY, CALIFORNIA. ON THE ROAD OF A THOUSAND WONDERS.

Veil, Vernal, Nevada and Illilovette are other magnificent and beautiful cascades, while there are also many smaller falls of equal or even greater altitude. The Ribbon Falls have an altitude of 3300 feet, but, owing to their narrowness, are ribbonlike in appearance; the Widow's Tears is a tenuous fall that becomes very slight or dries up entirely in the summer, and the Widower's Tears is an even less durable stream, that dries up still more quickly.

As one goes into the park several natural rocky

formations attract attention; one is a huge rock which at a little distance looks like an enormous elephant, while in another place the perfect figure of a cat is presented on the face of a precipitous cliff. El Capitan is a bare rock rising vertically 3300 feet in an unbroken mass and dominating the landscape for a long distance. Cathedral Rock is so-salled from its resemblance to the Duoma at Florence, while nearby are the Cathedral Spires which rear their gothic peaks high into the sky. Many other remarkable rock formations claim the attention of the visitor, but cannot be

EL CAPITAN, YOSEMITE VALLEY, CALIFORNIA.

mentioned more in detail in this short narrative. The valley itself is a natural park, level, verdant and umbrageous, with trees of many varities, a varied flora, noisy streams of water and a placid lake that reflects objects as in a mirror when the sun shows his face over the mountain's rim. This pool is called Mirror Lake, and amorous swains and their sweethearts delight to have their double presentment depicted from a rock a little distance from the shore.

Near the center of the valley is the Sentinel Hotel, which is a rather rough, but entirely comfortable, hostelry, with excellent food and service. A number of cottages are also close at hand to house the overflow. The cottage at which the writer lodged was built around a huge tree, which projected through the roof. Camps are also established at several points, where those who prefer to live the simple life can have their desire fulfilled. Life in the valley is rather unconventional, and one usually goes clad in his or her oldest and roughest clothes. The diversions are either walking or riding in the valley, or usually up the trail to Glacier Point, or to other points of vantage. From the hotel daily trips are made by stage to the Mariposa Grove of Big Trees, which are the oldest and largest living things in the world. It is believed that these trees are over 5000 years old. I did not have the opportunity to visit this particular grove, but did visit another of nearly equal size and antiquity. Instead of making the trip to the Mariposa Trees, the writer mounted the quarter deck of a rough horse and embarked on a bone and joint racking voyage of 15 miles up and down the trail to Glacier Point. As he had not employed this method of locomotion for 25 or 30 years, his most delightful moment was when he dismounted at the termination of the trip. Glacier Point is a bold projection overlooking the valley from an altitude of 3250 feet. It is rather difficult to reach for the tenderfoot, but amply repays the voyager for the discomforts of the ascent. Under the direction of competent guides tourists are escorted in long trains up the narrow and precipitous trails. At many points there are beautiful vistas of the mountains and valleys, and at other points we have near views of the magnificent falls. A portion of the trail is through thickly wooded stretches, where huge trees raise their lofty heads far into the azurean dome of the heavens, while frequently trees of considerable size grow from clefts in the rocks, where to the inexperienced eye there seems to be no soil whatever. In some places the trail is apparently cut out of the face of the cliff, and a misstep of your horse means a dash downwards of hundreds of feet. At such places your animal frequently takes especial delight in getting as near the edge as possible, while you would much prefer to remain as far off as you can get, or, with his feet braced on the rim of the trail, he reaches his head and neck into space to crop a twig that may project toward him. However, the animals are sure-footed and

trusty, and if you give them free rein they will bear you in safety to your destination. At the summit is a small hotel where you can get lunch, and if you prefer, remain overnight. The view from here is wonderful; for nearly 100 miles you see the snow-clad tops of the high Sierras, with peaks and intervening canyons forming a wild and jagged scene. From here also the valley appears to be a verdant garden, with roads like tapes running in various directions, and people and teams looking like ants and bugs as they walk or ride along the paths. The descent is by the short trail, which is much more precipitous than the one by which we ascended, and much shorter.

There is a regular moving picture outfit in the Yosemite, and here many of the scenes of robbery and assault that one wonders at in the theaters are carefully worked out. The Sentinel Hotel is kept open the year round, though the ground is covered with snow. It is said to have sufficient patronage from Californians, who come in order to enjoy the snow scene with which they are unfamiliar, to justify the effort. The National reservation is much more extensive than the valley, and covers an area of 36 by 48 miles. I suppose it is chiefly a wild animal range or a forest preserve, as it does not seem to be thrown open to the public. We left the valley in busses at 2 P. M. on July 3, and retraced our steps to El Portal, where we found our special train waiting, and resumed our journey in the evening. On the morning of July 4 we were running through a broad valley where grass and grain fields extended almost as far as the eye could reach, and where the farmers were busy gathering their harvest.

Nothing is more characteristic of California than its contrasts. In some sections one sees only orange groves; in another, lemon trees, olives, vineyards or vast tracts in which beets are the chief or only products. A considerable portion of the State is arid, and requires artificial irrigation to render the soil productive, while in other parts there is an abundance of water derived from the melting snowcap of the high mountains. A large area is treeless, except where planted and irrigated; other areas produce the largest, tallest and oldest trees in the whole world. The fruits are usually much larger than those of the same variety in other sections of the country, and in some instances are gigantic. Minerals are abundant, though there are other areas in which the precious metals are produced in greater quantities. There is a vast production of petroleum, and the oil wells are found even in the Pacific Ocean. The railroads use coal oil, as do the steamboats also, instead of coal, and it is certainly much more pleasant for the passenger, as there are no sparks and cinders to get into his eyes or to burn holes in his garments. Of course, there is smoke, but not tangible particles of dirt to distress one.

At 9 A. M. on July 4 we reached the pier at Oakland, and shortly thereafter were crossing the beautiful San Francisco Bay to the historic

VERNAL FALLS, YOSEMITE VALLEY, CALIFORNIA.

city of the same name, which, like a phœnix, is rising from its ashes into a new and more substantial, if less picturesque, city than the one that was destroyed five years ago. San Francisco Bay is a wonderful body of water, communicating with the Pacific Ocean by the narrow Golden Gate, large enough to float the navies of the world, and absolutely landlocked and safe. The cities of San Francisco, Oakland, Berkeley and Alameda, besides smaller towns, are clustered on the shores of the bay, and are populous and busy centers of trade and commerce.

INVERSION OF THE UTERUS, WITH A REPORT OF AN ACUTE CASE OF COMPLETE INVERSION AND ITS TREATMENT.

By E. H. Kloman, M.D.,
Associate in Obstetrics, University of Maryland.

I have hesitated reporting these cases for several months, as I feel that apologies are due for my attempting to write upon such a rare subject. Yet it is such a serious condition that I feel it my duty to report the cases, and in so doing give a few words upon the subject.

There are several varieties and grades of inversion, and likewise several etiological factors. As the only two cases which I have been called upon to treat have occurred in obstetrical practice, I will not attempt to discuss those cases belonging more clearly to gynecology.

The puerperal inversion is far more common than non-puerperal, and is generally said to be about 85 per cent. for the former and 15 per cent. for the latter. So rare is this condition that many prominent obstetricians never see a case. *Williams' Obstetrics* gives one case in 190,833 deliveries in London, while not a single case was found in 250,000 labors in the St. Petersburg Hospital. I am inclined to think it is more frequent than either of these instances would indicate, as it is a condition caused in large part by a careless accoucher or midwife, and naturally escapes the literature.

Puerperal inversion may either result from a full-term delivery or from an abortion. It may be complete or incomplete, all gradations occurring from a slight invagination of the fundus (most frequently near one of the horns) to a complete inversion of the uterus and vagina.

The predisposing etiological factors in inversion of the uterus are as follows:

The condition is most frequent in primipara, with distention or relaxation of the birth canal, a large pelvis, the erect posture during labor, a short cord, laceration of the cervix and attachment of the placenta or a tumor to the fundus. One or more of these causes, combined with a determining cause, are generally found to account for the condition.

Before giving the determining causes, I wish to say that the case which I report was one due to direct carelessness, and I make no excuse for its occurrence in our clinic, as it was a lesson to all who observed it. Fortunately, it terminated favorably.

Among the determining causes are, first, too vigorous use of Crede's method, or pressure on the fundus when the uterus is not contracted; traction on the cord; tumor of the fundus (this causes a great majority of non-puerperal inversions); blows on the abdomen or contraction of the abdominal muscles with an atonic uterus.

The weight of the abdominal viscera alone may cause it when the patient is in erect posture with a relaxed outlet and atonic uterus.

The symptoms are most frequently acute and alarming, marked by a nervous condition of the patient, faintness, post-partum hemorrhage, shock and marked pelvic discomfort in all grades of inversion. On the other hand, symptoms are sometimes slight, and the condition goes unnoticed.

If the inversion is complete, the diagnosis is simple, but if only a beginning inversion, as in my case when the fundal depression was slight, it is more difficult. Indeed, the complete inversion seems to be difficult at times, as I gather several cases from the literature when mistakes are made confusing the protruding fundus with the head or breech of the child, a mole, a clot, a polypus or placenta. I think these mistakes are made in consequence of the critical condition of the patient and the unsuspecting and alarmed practitioner.

As a result of this error in diagnosis, the uterus is torn away for a tumor, clot, placenta, or what not, and simultaneously the patient's life and the physician's reputation are lost.

Treatment.—The prophylactic treatment is the most important, as the condition is more frequently due to mismanagement than to unavoidable causes. And if the reader is ever so unfortunate as to have a case of complete inversion to handle, he will at once think of the familiar and true saying, "An ounce of prevention is worth a pound of cure."

Here are a few "don'ts" which may save you this embarrassment:

Don't try to express a placenta until it has become detached from the uterus.

Don't make pressure on the fundus when the uterus is soft, especially when the cervix is torn and the outlet relaxed.

Don't try to aid the expression of placenta by traction on cord.

If partial inversion occurs, it can usually be detected by palpation on the abdomen, when a depression will be felt in the uterus, generally accompanied with profuse hemorrhage. It is best to put the patient under an anesthetic at once. Prepare the patient and your hands aseptically; wear rubber gloves and introduce hand into uterus and replace the inversion. If the inversion is marked, I would advise a sterilized gauze pack. If only slight, and the uterus contracts freely, I think a hot normal salt douche would suffice, provided there is no marked post-partum hemorrhage after replacing inversion.

When the inversion is complete and seen at the time of labor, the placenta may be still attached. Most authorities advise leaving the placenta intact. In my case I detached it, as I was sure I would experience great difficulty in replacing the organ should I leave the large placenta attached over the very portion which I replaced first.

The hemorrhage was not increased by the detachment. I wiped the uterus with hot sterile salt and gauze after the removal of the placenta, and with the palm surfaces of both hands on posterior wall; I used the ends of thumbs to invaginate the fundus, gradually increasing the reinvagination until I could put my whole hand in the uterus.

This is very different if you see the case for the first time several hours after the accident, as the os will begin to contract and the replacement may become impossible. Then it is best to pack the vagina, after pushing the uterus back in the vault, and arrange for operative procedure in hospital if possible.

It is seldom necessary to do a hysterectomy unless such complications set in as gangrene from constriction of the os.

CASE NO. I. COMPLETE INVERSION OF UTERUS AND VAGINA FOLLOWING FORCEPS DELIVERY.

History.—Name, B. A.; white; single; age 18. Primipara—Pelvic measurements above average for girl 18 years; superior spines 27; crests 29; trochanters 31; Baudelocque's diameter 20.5. Patient went into labor at full term with occiput presenting. After 24 hours of labor the membranes ruptured, but the head made no progress in its descent with three hours of hard pain after the rupture of the membrane. A mid-forceps operation was done under chloroform anesthesia, resulting in the delivery of a very large living child with a cervical laceration extending almost to the left fornix of vagina. An assistant who was keeping watch over the uterus was requested to express the placenta when detached. This he failed to understand, and made pressure on the fundus of a relaxed uterus with a lacerated outlet. This resulted in a complete inversion of uterus and vagina, the placenta still attached to the uterus. A sudden gush of blood preceded the expulsion of uterus, but very little shock was noticed on part of patient, possibly due in part to her profound anesthesia. No great hemorrhage was evident, but the pulse rate ran as high as 140. I removed the placenta at once, and after wiping the endometrum with hot sterile gauze I grasped the posterior part of the body with the palm surfaces of hands and replaced the fundus, first by pushing up with the thumbs and finally introducing the whole hand into the cavity to see that replacement was complete and to aid contraction. This was followed by a hot douche and gauze pack. The cervical laceration was repaired later. Involution was complete, and uterus returned to its normal position. This patient suffered from vague pains for several months, but when seen six months after operation was in excellent condition, with no pain.

CASE NO. II. SEEN IN CONSULTATION WITH DR. ——. FORCEPS DELIVERY OF A 12-POUND CHILD.

Indications.—Uterine inertia due to large child and hydramnios. Shortly after delivery the placenta was found free in vagina; hemorrhage was profuse, and when attempting to massage the fundus a distinct depression was noticed in the left horn of uterus. Hemorrhage became alarming, and as uterus did not make any attempt to contract or retreat, I introduced one hand into the cavity and found a partial inversion. This was replaced at once and followed by a hot douche and massage, with a firmly retracted and contracting uterus resulting. It is very easy to make a mistake and call a partial inversion a tumor or polyp. In one case of partially inverted uterus, erroneously supposed a polyp, the protrusion was pulled down through the external os and removed by amputation, resulting fatally.

1619 St. Paul Street.

Dr. Hugh Warren Brent, class of 1903, is located at 906 N. Calvert street, Baltimore, Md.

FISTULA IN ANO.

By M. E. Mallen,
Senior Medical Student.

Fistula in ano is the unhealed track of an abscess, which is tubercular in 95 per cent. of cases. There are three different kinds of fistula in ano—(1) the blind external, (2) the blind internal, and lastly the complete. In the first variety an opening exist from the skin around the anus to the perirectal soft parts, thus not communicating with the rectum. In the blind internal an artificial opening projects from the rectum into the surrounding tissues, but not reaching the skin. In the last variety there is a complete opening from the rectum through the skin. In tubercular fistula the external opening is rather large and very irregular, with thin edges, shows no granulation through which is discharged small amounts of blood-tinged pus, and congestion of the immediate skin is to be observed.

Etiology.— As 95 per cent. of fistula in ano is due to tuberculosis—and in most cases it is a secondary process—we should always ascertain as to the presence of tuberculosis in the adjacent structures. It is usually the drainage tract of ischio-rectal abscesses, tubercular ulcers of the rectum, anal abscess, etc.

Symptoms.—The symptoms of a complete fistula are the passage of feces or gas through the opening. After a time incontinence of feces is apt to occur as a result of thickening of the mucosa of the rectum from repeated attacks of inflammation, which partly or wholly destroys its sensibility. From time to time the opening will be blocked and new abscesses be formed. In probing a fistula use a thin, easily-bent instrument.

Treatment.—First in importance is cleanliness. The rectum should be irrigated with hot normal salt solution. Never use antiseptics in the rectum. Place the patient in the lithotomy position. Pass a groove director into the external opening to the bowel and bring the other end externally. Cut upon this. Cut the sphincter at a right angle to its fibres, and only once. It is best in tubercular cases to separate the tissues with a cautery. Search with a small probe for branching sinuses, and if found slit them open. Curet all the sinuses found. Remove superfluous tissues, irrigate with normal salt solution, pack tightly with iodoform and apply a T bandage. Dress every day. If sluggish, touch up with silver nitrate. Bowels should be constipated after the operation.

Anesthetic.—Anesthetize the patient with ether, unless the fistula is tuberculous, in which case use local anesthesia—quinine muriate and urea. Ether is to be avoided if phthisis exists, as its inhalation is often followed by a dissemination of the process. It may even relight a quiescent tubercular lesion.

Amongst our Florida alumni are:

James E. Rawlings, '04, 10 Beach street, Daytona.

George W. Betton, '95, 539 Riverside avenue, Jacksonville.

Norman M. Heggie, '02, Buchanan Building, Jacksonville.

Charles L. Jennings, '06, 305 Cedar street, Jacksonville.

James D. Love, '97, 501 Laura street, Jacksonville.

Robert H. McGinnis, '97, 501 Laura street, Jacksonville.

Robert L. May, '90, 38 W. Beaver street, Jacksonville.

L. Denham Parker, '72, 306 W. Forsyth street, Jacksonville.

Joseph L. Romero, '79, 2109 Kershell street, Jacksonville.

Charles Edward Terry, '03, 118 W. Adams street, Jacksonville.

George Walter, '10, 131 W. Adams street, Jacksonville.

Frederick J. Wass, '05, 136 E. Duvall street, Jacksonville.

Abner J. P. Julian, '83, Lake City.

Hugh W. Henry, '91, Lake Wier.

George W. Brown, '89, Lawtey.

Lester Julian Efride, '03, Live Oak.

Arthur L. Izlar, '89, 71 Wenona street, Ocala.

Calvin T. Young, '03, Plant City.

John Cox Keaton, '07, Quincy.

Samuel Puleston, '02, Sanford.

Benjamin J. Bond, '04, Tallahassee.

Fred Clifton Moore, '03, Tallahassee.

Henry Edwards Palmer, '92, Lafayette and Adams streets, Tallahassee.

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Rollin Jefferson, '03, 508 Twiggs street, Tampa.

J. Brown Wallace, '97, 706½ Franklin street, Tampa.

THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, NOVEMBER 15, 1911.

"GIVE, NOT GRUDGINGLY, OR OF NECESSITY; FOR GOD LOVETH A CHEERFUL GIVER."

"The people rejoiced for that they offered willingly; * * * and David the King also rejoiced with great joy."

King David had in his heart to build a temple at Jerusalem, and he began to make preparation for this great undertaking. First, he gave freely of his own treasure, and then he called upon the people to aid in the work, and the monumental record remains to this day, that they gave willingly with rejoicing. We do not wish to be considered flippant, or to apply lightly to a secular enterprise the words of sacred writ, yet it seems as if the truths contained in the record quoted are applicable to the undertaking in which we are engaged. In a sense we are building, or attempting to perpetuate, a temple of medical science at which we have received instruction, inspiration and manifold advantages. After more than a century of honorable and useful endeavor, the medical school of the University of Maryland finds itself confronted with new conditions and new problems. The times have changed, and we must change with them. For some months we have been appealing to our alumni and others for assistance. The object of this effort, which is entirely altruistic on our part, should appeal to the loyalty, gratitude and generosity of those who have received marked benefits from the institution. It ought not to be necessary to beg such individuals for contributions to the endowment fund, but they should give willingly according to their several ability. Recognizing the imperative necessity of placing our school on a solid basis, the writer has undertaken a task that is exceptionally distasteful to him. He has no expectation whatever of any personal gain from his efforts, and his only desire is to see his school firmly fixed upon a sure foundation. Brethren, help us with your money, your work and your constructive advice.

LET US LIST YOU AS A SUBSCRIBER TO THE PATHOLOGICAL ENDOWMENT FUND.

The subscriptions to November 1 are as follows:

Robinson bequest	$5000
Dr. Hugh Hampton Young, J. H. U.	100
Prof. R. Dorsey Coale, Ph.D.	100
Dr. S. J. Meltzer, LL.D., New York	10
Dr. Gideon Timberlake	25
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Dr. Joseph T. Smith, 1872	10
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Dr. Robert Gerstell, 1873	5
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Dr. H. T. Harrison, 1874	5
Dr. John D. Fiske, 1875	5
Dr. Wilmer Brinton, 1876	100
Dr. Wm. E. Wiegand, 1876	10
Dr. Thos. Chew Worthington, 1870	5
Dr. R. H. P. Ellis, 1877	10
Dr. Charles W. Mitchell, 1881	100
Dr. L. Ernest Neale, 1881	100
Dr. E. L. Meierhof, 1881	50
Dr. J. M. Hundley, 1882	250
Dr. Henry Chandlee, 1882	10
Dr. Henry Chandlee, 1882	15
Dr. B. Merrill Hopkinson, 1885	25

Dr. J. C. Perry, 1885	100
Dr. H. C. Reamer, 1885	10
Dr. Frank Martin, 1886	100
Dr. John R. Winslow, 1888	50
Dr. C. W. McElfresh, 1889	100
Dr. Saint Clair Spruill, 1890	100
Dr. Rupert Blue, 1892	100
Dr. Frank J. Kirby, 1892	50
Dr. Walter B. Kirk, 1893	5
Dr. Martin J. Cromwell, 1894	50
Dr. Charles T. Harper, 1894	50
Dr. Harry Adler, 1895	100
Dr. Jose L. Hirsh, 1895	50
Dr. Joseph W. Holland, 1896	50
Dr. R. W. Sturgis, 1896	2
Dr. Guy Steele, 1897	15
Dr. Page Edmunds, 1898	50
Dr. Albert J. Bossyns, 1898	5
Dr. L. W. Armstrong, 1900	10
Dr. S. Demarco, 1900	50
Dr. M. S. Pearre, 1900	5
Dr. Irving J. Spear, 1900	50
Dr. Wm. Tarun, 1900	50
Dr. J. D. Reeder, 1901	50
Dr. Nathan Winslow, 1901	50
Dr. Wm. R. Rogers, 1901	25
Dr. Arthur M. Shipley, 1902	250
Dr. H. C. Davis, 1902	10
Dr. H. L. Rudolf, 1902	25
Dr. Hugh Brent, 1903	25
Dr. G. C. Lockard, 1903	25
Dr. Geo. S. M. Kieffer, 1903	25
Dr. H. J. Maldeis, 1903	25
Dr. Howard J. Iglehart, 1903	25
Dr. R. C. Metzel, 1904	10
Dr. Ejnar Hansen, 1904	10
Dr. Robert P. Bay, 1905	100
Dr. B. F. Tefft, 1905	100
Dr. Jos. A. Devlin, 1906	10
Dr. W. F. Sowers, 1906	25
Dr. Robt. W. Crawford, 1906	25
Dr. Leo Karlinsky, 1906	20
Dr. J. F. Hawkins, 1906	25
Dr. Frank S. Lynn, 1907	25
Dr. T. H. Legg, 1907	5
Dr. Albert H. Carroll, 1907	25
Dr. Edgar S. Perkins, 1907	25
Dr. J. N. Osburn, 1909	5
Dr. E. H. Kloman, 1910	25
Total	$870 2

Additions for the month $500.

THE MARYLAND STATE BOARD REPORT FOR JUNE, 1911.

There has been considerable uncertainty as to the result of the examination of the Maryland State Medical Examining Board in June, 1911. The manner in which the results are tabulated is a very unfortunate one, and it is impossible for a person who has not made a long study of these reports to interpret them correctly; indeed, it is often impossible for an expert to determine accurately the results. The report for June, 1911, as published in the *Maryland Medical Journal* and in the *Bulletin of the Medical and Chirurgical Faculty of Maryland* was no exception in this respect. After considerable correspondence with Dr. J. McPherson Scott, secretary of the Board, we think we have now arrived at a correct understanding of the results, as far as our own graduates are concerned. The *Maryland Medical Journal* report is erroneous, in that we are credited with fewer successful candidates than we were entitled to, as Drs. Jas. E. Quigley and S. H. Rynkiewicz are credited to Jefferson Medical College, and not to the University of Maryland; and, on the other hand, we had four failures instead of three. The results, therefore, are 34 applicants passed and 4 failed. Of the class of 1911, 27 passed and 2 failed.

The following is the correct list of those who passed successful examinations and received licenses to practice medicine in Maryland, with the year of graduation:

Francis H. Digges, 1904.
Geo. E. Bennett, 1909.
Chas. A. Neafie, 1909.
John G. Schweinsburg, 1909.
R. Gerard Willse, 1909.
W. Van V. Parramore, 1910.
Nathaniel Garb, 1910.
Jacob B. Asper, 1911.
Walter O. Bacon, 1911.
Buchler S. Boyes, 1911.
William L. Byerly, 1911.
Henry D. Causey, 1911.
Herbert A. Codington, 1911.
Louis H. Douglass, 1911.
Chas. L. Dries, 1911.
Jas. J. Edelen, 1911.
A. L. Hornstein, 1911.
Kenneth B. Jones, 1911
Chas. H. Keesor, 1911.

Chas. R. Law, Jr., 1911.
Isaac M. Macks, 1911.
Geo. Y. Massenberg, 1911.
Walter S. Niblett, 1911.
Elijah E. Nicholls, 1911.
Vernon L. Oler, 1911.
John Astro, 1911.
Jas. E. Quigley, 1911.
S. H. Rynkiewicz, 1911.
Chas. L. Schmidt, 1911.
Joseph Stomel, 1911.
Ralph L. Taylor, 1911.
Grafton D. Townsend, 1911.
Albert G. Webster, 1911.
Richard L. Williams, 1911.

ABSTRACT

The *New York Medical Journal*, October 7, 1911, publishes an article by Dr. Harry Adler, class of 1895, and Dr. Howard Elmer Ashbury, class of 1903, entitled "Further Experience in X-ray Diagnosis of Ulcer of the Stomach and Duodenum, Embracing Seventy-five Cases," in which the following appears:

"Our first work on this subject was presented before the Medical and Chirurgical Faculty of Maryland in April, 1910, with a report of six cases of ulcer diagnosticated by the X-ray. A second paper was presented before the American Röntgen Ray Society in September, 1910, entitled 'X-ray Findings in Gastric and Duodenal Ulcer.' At that time 45 cases had been examined. Since then we have made X-ray examinations of 30 additional cases, making a total to date (March 20, 1911) of 75 cases. Our intention in presenting this paper is to bring before the society the Röntgen method as a distinct advance in the diagnosis of ulcers, and as a probable means of determining results of treatment when used in connection with clinical symptoms.

"In our efforts to locate gastric and duodenal ulcers we have chosen a systematic and constant technique, and by careful interpretation of plates have been able to eliminate most sources of error. Any addition to the present means of diagnosticating ulcers will be of great assistance and the treatment will be much more satisfactory if we are able to approximate the size and location of the ulcer. The principle of the method is based upon the idea that the crater of an ulcer will retain a salt of bismuth after the normal mucosa has been cleared of it by the peristaltic action of the stomach and intestine. Dr. Hemmeter, before this association, at the meeting in Boston, spoke of the possibility of X-ray demonstration of gastric ulcer; and while no plates were shown in evidence, it is due to the inspiration of his suggestion that this work was undertaken by us.

"That a gastric ulcer will retain bismuth is evidenced by the following case reported by Naunyn: A patient who had had a profuse gastric hemorrhage was given 20 grammes of bismuth subnitrate 36 hours before death, and 24 hours later an additional 5 grammes were given. Autopsy showed that the ulcer was filled with a clump of bismuth, about 20 grammes in weight, while the remainder of the stomach contained a very small quantity. With the idea of investigating the behavior of bismuth with artificial ulcer, the following experiment was carried out by Dr. Robert P. Bay of the University Hospital (Baltimore):

"'A dog was put to sleep, the abdomen opened, and an incision made into the stomach. Through this incision a portion of gastric mucosa was delivered from the opposite wall by means of an artery forceps. An artificial ulcer was produced by denuding the mucosa down to the muscular layer. The edges of the stomach incision were likewise denuded, thus creating two artificial ulcers on opposite sides of the stomach one and a half inch from the pylorus. This incision was then sutured and the abdomen closed. The dog was fed on the third day after the operation with some scraped meat containing four grammes of bismuth. Three hours later an X-ray picture was taken. Two and five hours thereafter other radiographs were made. These plates showed bismuth retained above the sites of the ulcers.

"'This conforms with the findings of Cannon, that there is a temporary paralysis of the muscle at the point of the operation. Two days later a second series of plates were taken three, five and eight hours after four grammes of bismuth. These showed a lessened retention of bismuth than in the first series. A plate taken 24 hours after the bismuth showed retention practically only at the site of the ulcer.'

"The following conclusions have seemed to us justifiable: First, the retention of bismuth, given according to our method for a period over four hours, signifies a pathological condition other than mere displacement; second, the absence of the bismuth shadow from the stomach area, except-

ing in small isolated spots, is not due to stenosis or simple dilatation, but to ulcer.

"While we believe that a distinct advance has been made in ulcer diagnosis, that a valuable sign has been developed which, when present, will justify us in carrying out our treatment with assurance in otherwise doubtful cases, yet we feel that the X-ray examination should not as yet be looked upon as giving by itself a final verdict, but rather should bear weighty evidence when taken in conjunction with the other clinical data.

"The X-ray examination having shown a definite ulcer shadow before treatment is instituted, its persistence or absence in later radiographs after the treatment should be an index of the result of such treatment. Some work has been done on this line, but our experience is too immature to report data of value."

ITEMS

While it has long been recognized that the constant changing of the student body and the necessary shifting of control of the various teams of the University of Maryland did not tend to further the best interests of athletics, it remained to the foresight of Dr. Frederick H. Vinup, class of 1909, to agitate the advisability of the formation of an alumni athletic association, which should assume control and thus assure a stable management. With this purpose in view, Dr. Irving J. Spear, class of 1900, president, called a meeting of the Adjunct Medical Faculty in Davidge Hall on October 10 for the purpose of considering the advisability of such a step. The consensus of opinion of those present was that an athletic alumni association should be organized, and in order to carry out this object Dr. I. J. Spear was elected temporary chairman, and Dr. Nathan Winslow, class of 1901, temporary secretary-treasurer.

The chair appointed Drs. R. Gerald Willse, class of 1909; Robert L. Mitchell, class of 1905, and Homer Ulrich Todd, class of 1908, a committee to formulate by-laws for a permanent organization. At a subsequent meeting the temporary officers were made permanent, and Mr. Edgar Allan Poe, the Attorney-General elect of the State, was elected vice-president, and Dr. Robert Levis Mitchell, class of 1905, graduate manager of athletics. The officers have determined to have the association incorporated, and also to petition the Board of Regents for authority to act as their official representative in matters pertaining to athletics.

It is not to be understood that the Alumni Athletic Association desires or intends to infringe upon the students' rights, its chief function being merely supervisory in character, the regulation of team membership and the control of the financing of the several athletic teams.

As heretofore, the students will have an athletic association of their own, which is, however, to occupy a subsidiary position to the Alumni Athletic Association. The undergraduate athletic association will elect their own officers and managers, and arrange their own schedules on the advice of the graduate manager of athletics.

As an avenue for open intercourse between the student and alumni athletic associations, the by-laws provided for the formation of an Alumni Athletic Advisory Council, which is to be composed of the officers of the Alumni Athletic Association and four representatives (one from each department of the school) from the undergraduate association. This council is the court of last resort concerning the eligibility to team membership, games to be played, guarantees to be offered and accepted, schedules, etc.

It is the hope of those interested that at last athletics at the University have been placed on a firm basis.

Membership dues are fixed at $1 per annum, and all members are given a card granting free admittance to all games played in Baltimore under the auspices of the Association. Those desiring to become members may send their names to the secretary-treasurer, Dr. Nathan Winslow, 608 Professional Building, Baltimore.

Dr. Edson W. Glidden, Jr., class of 1907, formerly superintendent of the Georgia State Sanitarium, was a recent visitor to the University Hospital.

Dr. Louis Miner Allen of Winchester, Va., formerly associate professor of obstetrics in the University, was a recent visitor to the University Hospital.

Drs. Randolph Winslow, class of 1873; L. Ernest Neale, class of 1881; Robert Parke Bay, class of 1905; E. H. Kloman, class of 1910, and Albert Hynson Carroll, class of 1907, attended

the second annual session of the Clinical Congress of Surgeons of North America, held in Philadelphia, November 7 to 16, 1911.

The following graduates of the University of Maryland are members of the United States Public Health and Marine Hospital Service, and are stationed as follows:

James C. Perry, class of 1885, Ancon, Canal Zone.

James A. Nydegger, class of 1892, New York, New York.

Rupert Blue, class of 1892, San Francisco, Cal. (Epidemic duty.)

Henry W. Wickes, class of 1892, Cairo, Ill.

John McMullen, class of 1895, Immigration Service, Baltimore, Md.

E. H. Mullan, class of 1903, Immigration Service, Ellis Island, New York, N. Y.

Lawrence Kolb, class of 1908, Reedy Island Quarantine Station, Port Penn, Del.

Julian Mason Gillespie, class of 1910, Honolulu, Hawaii.

Dr. Gilbert Tyson Smith, class of 1897, has been appointed by the Canadian Government medical supervisor of the Indian village at Rampart House, where an epidemic of smallpox is raging. Dr. Smith has been for some months with the Alaskan Boundary Survey.

Dr. Newdigate Moreland Owensby, class of 1904, was formally installed as superintendent of the Maryland Homeopathic Hospital, Baltimore, September 16.

The following letter has been received by Prof. Randolph Winslow from Dr. Ejnar Hansen, class of 1904, of 221 W. 57th street, New York:

"Dear Dr. Winslow:

"I should have answered your letter long ago, but I have been in bed for the last two weeks with a bad knee. I was making a call on a steamer when I stepped on a piece of wire rope and dislocated my kneecap. I am sure when Shipley hears that he will say to himself: 'Well, well; Hansen on a steamer, a bad knee; I suppose that the breakfast was a good one.' Please tell him that the accident happened before breakfast, and I am now beginning to get up a little every day, and by help of crutches I can make my way to my office a couple of times a day.

"I see in THE BULLETIN only one of the class of 1904 contributing to the fund. I think it a very poor result. We were rather a large class. I am sending you a small check, and only wish all the rest would do the same. Give my best regards to old friends who still remember me.

"Yours sincerely,

"EJNAR HANSEN.

"Where is Hugh Brent? Still in South America?" (See page 171.)

Dr. John Aldridge Gibson, class of 1911, of Leesburg, Va., sent us a photograph of his new home, which has just reached completion. The house is built of concrete, two and a half stories high, with a big hospitable-looking Colonial porch in the front and a handsome Colonial doorway leading into the house.

Dr. J. Frank Crouch, class of 1890, has removed his office to 513 N. Charles street.

Dr. James M. Craighill, class of 1882, clinical professor of medicine in the University of Maryland, has removed his residence and offices to the Walbert, Charles street and Lafayette avenue. For many years Dr. Craighill has been one of the most prominent and successful physicians in Baltimore, and has always taken an active interest in every movement for the betterment of the University of Maryland.

We are much indebted to Dr. G. Lane Taneyhill, class of 1865, for the kindly assistance given in the preparation of the account of Dr. John Reese Uhler's life. In the skin-grafting operation reported therein Dr. Taneyhill killed the mice and did all the mice skin-grafting himself. Then both Drs. Taneyhill and Uhler gave skin from their own arms, the scar of which Dr. Taneyhill still bears.

The General Alumni Association will hold its annual banquet on Monday, November 13, at 7.30 P. M., in the Hotel Rennert. A business meeting for the election of officers will precede the banquet, this being called at 7 P. M. Governor

Crothers; Mayor Preston; Prof. C. Alphonso Smith, the Edgar Allan Poe professor of the University of Virginia; Mr. J. Walter Lord of the Baltimore bar; Mr. T. Scott Offutt of the Towson bar and Mr. Carl Schon, entertainer, have promised to attend, and the evening promises to surpass anything that has ever been given by the General Alumni Association.

We are glad to report that Dr. Charles W. Famous, class of 1901, of Street, Md., was elected to the House of Delegates from Harford county on the Republican ticket by a vote of 2638 and a majority of 282 over his Democratic opponent—Sullivan. As Harford is an old Democratic stronghold, and as Dr. Famous was the only Republican winning election in that county in the election just passed, we consider his selection by the people a high tribute to his personality.

Amongst our Alabama alumni are:

William Groce Harrison, '92, Empire Building, Birmingham.

Howell Towles Heflin, '93, 109½ N. 20th street, Birmingham.

Devotie Dennis Jones, '72, Woodlawn, Birmingham.

E. Lawrence Scott, '06, Bissell.

Lewis Green Woodson, '87, 1326 S. 19th street, Bissell.

Thomas Jefferson Powell, '66, Childersburg.

Eugene Walker Hart, '91, Walnut Hill, Dadeville.

James Columbus Cousins, '91, Equality.

Andrew Lee Wynn, '80, 5th street, Florala.

H. R. Bell, '79, Pansey.

William Gibson Floyd, '85, Roanoke.

Dr. Norman McLeod Heggie, class of 1902, of Jacksonville, Fla., has been quite ill with typhoid fever, but is now much improved, though he is not yet able to be up.

Among the recent visitors to the University Hospital are Drs. Charles Edward Terry, class of 1903, of Jacksonville, Fla.; Benjamin H. B. Hubbard, class of 1895, of Whitestone, Va.; Charles Wesley Roberts, class of 1906, of Douglas, Ga.; Russell Wesley Raynor, class of 1908, of Whitehaven, Md.: Harry C. Chappelier, class of 1897, of Hughesville, Md., and Frederick De Sales Chappelier, class of 1904, of Lewes, Delaware.

Dr. Wilbur Pledge Stubbs, class of 1905, who has been ill at the University Hospital, has sufficiently recovered to be able to go to his home, 1504 Hollins street, Baltimore.

Dr. Henry B. Gantt, class of 1880, of Millersville, Md., who was a patient at the University Hospital with an infected hand, has sufficiently recovered to return home.

Dr. Nathaniel Garland Keirle, class of 1858, director of the Pasteur Institute of Mercy Hospital and city post-mortem physician, reached his eightieth birthday on October 10. Dr. Keirle put in the day hard at work, healthy and vigorous as ever.

Amongst our Tennessee alumni are:

Arthur J. Edwards, '99, 210 Solar street, Bristol.

Landon H. Gammon, '92, Bristol.

William Russell Rogers, '01, Bristol.

William A. Dietrick, '79, Miller Building, Chattanooga.

John Thomas Shepherd, '74, Loveman Building, Chattanooga.

John S. B. Woolford, '96, 313 Chamberlain avenue, Chattanooga.

John J. Harwood, '99, Halls.

Ellcanah Zion, '88, Kodak.

Samuel Lee Edwards, '99, Randolph Building, Memphis.

Wm. Caldwell Bilbro, '84, Murfreesboro.

BIRTHS

October 9, 1911, James Dawson Reeder, Jr., son of Dr. James Dawson Reeder, class of 1901, and Mrs. Reeder, 639 N. Fulton avenue, Baltimore, Md.

MARRIAGES

Dr. Emil Heller Henning, class of 1908, was married to Miss Caroline D. Kinstendorff of Hamilton and Carter avenues, Hamilton, Md., at the parsonage of Grace Evangelical Lutheran Church, Hamilton, on November 7, by the pastor, Rev. O. C. Mees. Dr. Henning served for a time as resident physician at Bayview Hospital. The couple will make their home with the bride's par-

ents, Mr. and Mrs. Augustus Kinstendorff, at Hamilton.

Dr. Roscoe Conkling Metzel, class of 1905, and Miss Daisy L. Hines, daughter of the late William M. and Mrs. Anna Webster Hines, of Belair, Md., were married in the parlors of Strawbridge Methodist Episcopal Church, Baltimore, October 19, 1911.

The wedding was attended by the immediate families only. The attendants were Miss Bessie Gore of Glyndon and Messrs. William M. Hines, brother of the bride, and Thomas B. and Olin Metzel, brothers of the groom. The couple will reside at 1903 W. North avenue, Baltimore.

Dr. Thomas J. Talbott, class of 1895, and Mrs. Mary Carland, both of Baltimore, were married October 9, 1911, at Memorial Protestant Episcopal Church by Rev. Dr. William Page Dame. Mrs. Carland is a daughter of the late Carroll Bradford of Baltimore. The couple left for a Northern trip, and upon their return will reside at 642 W. North avenue, Baltimore.

DEATHS

Dr. John Reese Uhler, class of 1861, died at his home in Baltimore, 1531 McCulloh street, on October 9, 1911.

Dr. Uhler was one of the best-known surgeons in Baltimore, and it was as a Baltimore physician that he attained fame all over the country. He was born here May 3, 1839, the son of George W. and Anna M. Reese Uhler. He attended a private school in Baltimore, and then studied pharmacy at the Maryland College of Pharmacy. He afterwards studied medicine at the University, graduating in 1861, his course of studies there being under the teachings of Profs. Samuel Chew, Christopher Johnson and Edward Warren.

In 1862, during the war, Dr. Uhler, who had begun the practice of medicine in this city in April, 1861, was made acting assistant surgeon in the United States Army. It was while in this service that he discovered a method of telling whether a ball was lodged in a person's body before probing for it. This was before the porcelain or Garibaldi probe was in use on the field. In 1864 the young physician was commissioned surgeon of the Fifth Maryland Volunteer Infantry, serving with this body until the close of the war.

In 1867 Dr. Uhler was appointed resident physician at Bayview Asylum, remaining there until 1868, when he went abroad. He took a post-graduate course in the lectures and a laboratory course at King's College, in London, later taking a further laboratory course at Johns Hopkins University and at Johns Hopkins Hospital.

In 1869 Dr. Uhler, in conjunction with Dr. G. Lane Taneyhill, class of 1865, performed what was probably the first skin-grafting operation in Baltimore. A horse car ran over a boy named B. F. Miller, crushing his body and tearing the flesh from his left hip, and causing serious internal injuries. Dr. Taneyhill had the case, and called Dr. Uhler into consultation. Dr. Taneyhill performed by himself the grafting of skin from mice upon the patient, killing the mice himself. Dr. Taneyhill thus describes it: "I secured 8 nidi (out of the 13 I grafted), and they made a beautiful cluster of islands. Dr. Uhler and myself also gave skin from our own arms." The boy finally regained perfect health.

In mentioning Dr. Taneyhill, we may add that Drs. Uhler and Taneyhill served together in the Union Army.

Besides being one of the founders of the Baltimore Medical College, Dr. Uhler at one time served as professor of surgery and as professor of chemistry at that institution. He was a member of the American Medical Association, the Medical and Chirurgical Faculty of Maryland, one of the founders and at one time president of the Baltimore Medical Association, a member of the Maryland Academy of Sciences, the Surgical Society of Baltimore, the Pathological Society of Baltimore and one of the founders of the Clinical Society of Baltimore.

He was also a member of and at one time a regent of the Royal Arcanum, and an active member of the Independent Order of Heptasophs. Dr. Uhler is survived by one daughter (Miss Grace Elma Uhler), two sons (Messrs. John Ridgely and Allan Hamilton Uhler), three sisters (Misses Mary A., Georgia and Miriam Uhler) and two brothers (Dr. Philip Uhler, provost at Peabody Institute, and Mr. Harvey Uhler).

Interment was in Greenmount Cemetery. Drs. Taneyhill, Carville V. Mace, class of 1897, and Wilbur Phelps Morgan, class of 1862, served as pallbearers.

Dr. Napoleon B. Nevitt, class of 1857, died at his home in Accotink, Va., September 25, 1911,

aged 81. He served during the Civil War as a Confederate surgeon.

Dr. Lawrence Sterling Alexander, class of 1868, died at his home in St. Augustine, Fla., November 6, 1910, from heart disease, aged 68 years.

Dr. Oliver J. Gray, class of 1902, died at his home in Wilmington, Del., September 29, 1911, of pneumonia, aged 31 years.

We have learned of the recent death of Dr. George Edward Gilpin, class of 1882, of Berkeley Springs, W. Va., aged 65 years.

BOOK REVIEWS

The Parasitic Ameba of Man. By Charles F. Craig, M. D., Captain, Medical Corps, United States Army. From the Bacteriological Laboratory of the Army Medical School, Washington, D. C., and the Rockefeller Institute for Medical Research, New York City. Published with the authority of the Surgeon-General of the United States Army. Philadelphia and London: J. B. Lippincott Company. Cloth, $2.50 net. 1911.

The literature on amebic infections in man has been so scattered that a person desiring any information on the same had to wade through a mass of material to worm out that which he sought. Thanks to the energy of Dr. Craig of the United States Army, this is a thing of the past. Now all one has to do is to consult Craig's "Parasitic Amebe of Man," where can be found the life history, general morphology, classification and nomenclature, the ameba of the intestinal tract, of the mouth, of the genito-uninary tract and those occurring in exudations, abscesses and in the lungs. The book is well written and in a pleasant style. The contents have added value, in that they are not merely a compilation of what others have written, but a resume of actual contact with the affection and laboratory experiments carried on by the author in the bacteriological laboratories of the Army Medical School and the Rockefeller Institute. Unlike many publications, it is a distinct addition to medical thought, and should be found of material benefit to bacteriologists, teachers, students, internists and surgeons.

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially-Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners. By leading members of the medical profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A. With the collaboration of Wm. Osler, John H. Musser, A. McPhedran, Frank Billings, Charles H. Mayo, Thos. H. Rotch, John G. Clark, James J. Walsh, J. W. Ballantyne, John Harrold, Richard Kretz. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels and Carlsbad. Volume III. Twenty-first series. Philadelphia and London: J. B. Lippincott Company. Cloth, $2 net. 1911.

The alert physician must have literature on the several specialties, internal medicine and surgery if he expects to keep abreast of the times. This can be obtained in various ways, but generally only after wading through a mass of unreliable material. In order to obviate this useless waste of time, the Lippincott Company has been issuing for a number of years absolutely trustworthy articles from the pens of recognized authorities. The present volume is no exception to its predecessors, in that it contains the latest and best thought on questions of vital interest to specialist and general practitioner. The fields of therapeutics, medicine, surgery and the other branches of medicine are all represented by articles by distinguished men. Some of the contributors to the present volume are Harlow Brooks ("The Modern Treatment of Arterio-Sclerosis"), James J. Walsh ("Heart Therapeutics and the Individual Patient"), Thomas R. Brown ("The Relationship Between Gastric and Urinary Acidity"), Paul V. Anderson ("Physical and Mental Hygiene in the Young, With Remarks Upon the Development of Dementia Precox"), E. H. Bradford ("The Surgical Treatment of the Disabilities Following Anterior Poliomyelitis"), Robert Jardine ("The Retraction Ring As a Cause of Obstruction in Labor"), etc. Surely from this list the most fastidious taste will find something to interest and benefit.

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A HURRIED TRIP THROUGH EUROPE.

By T. A. Ashby, M.D.

(Continued from November Issue.)

Our stay in Brussels was much too short to enable us to visit the many places of interest there. The impression made upon our minds was that it is a very beautiful and cosmopolitan city, resembling in the character of its public and private buildings and its social life Paris and Berlin. The Royal Palace, Palace of Justice, Cathedral of St. Gudule, the Bourse, and many other buildings are large and noble structures, reflecting great credit upon the artistic taste and liberality of the people of Belgium.

The streets of Brussels are broad and splendidly paved. They are kept thoroughly clean and in thorough repair. Waterloo avenue greatly resembles Eutaw Place in Baltimore in its Central Park and beautiful buildings lining its broad streets on both sides of the park. The park itself does not compare in beauty with that in Eutaw Place from the fact that it has no grass or flower beds but simply rows of trees surrounded with sand upon which the children and dogs are invited to play, the idea, perhaps, being to keep them off the streets. This condition was noticed also in the parks in London and Paris, where thousands of children were to be seen romping and playing all kinds of games. The health and pleasure of the children are considered of more importance than green plats or flower beds.

Brussels had a population of some 900,000. It is so cosmopolitan that Dutch, French, German and English are equally well spoken by the educated class of people. Many of the car conductors speak all of these languages. French customs and ways are so much in vogue that one can easily imagine that he is in Paris. Brussels is a city of large wealth and enterprise. Its looms and factories produce the finest carpets, tapestries, laces, gold and silver ware to be found in Europe. Owing to the great heat of the weather at the time of our visit we were not able to see the battlefield of Waterloo, 30 miles distant. We learned enough from tourists, who had been there, to satisfy us that we missed very little as comparatively little has been done to beautify the place.

The ride on the train from Brussels to The Hague in Holland was a journey of less than four hours, yet it was so filled with scenes and interesting objects as to make a memorable impression on our minds. Every mile of territory presented some new object or scenery different from any of my previous experiences. The country through which we passed was very low land cut into many strips by ditches and canals, which acted as substitutes for fences. On these lowlands there were grazing many thousand Holstein cows and calves, as also horses and sheep. I counted as accurately as I could from the car window over 300 cows in one large field. All of this lowland was in pasture or hay fields. The country was very closely settled with villages and towns whilst the famous windmill was dotted here and there, its huge wings revolving under the pressure of the air, now slowly, now rapidly, presenting a picture only seen in Belgium and Holland. These great machines do an enormous work in pumping water from the low canals over the dykes into the sea. But for the windmills much of this lowland would be submerged. The distance from Brussels to Antwerp was covered by our train in less than 40 minutes.

Antwerp is located on the River Schelde not far from where it empties into the North Sea. No city in Europe has, perhaps, had a more stormy and eventful history. During the reign of Charles

V it was the largest seaport in the world. Its harbors and docks were alive with ships which navigated every section of the then civilized world. Its commerce both in exportation and importation was enormous, and brought great wealth and prosperity to the city and to the Netherlands. No city in Europe at that time enjoyed greater renown as a center of culture, elegance and enterprise. When Philip II of Spain fell heir to his father's rule in the Netherlands he introduced the Inquisition into that country which brought in a few years complete desolation and ruin throughout Belgium and Holland.

Antwerp was among the first cities to feel the hand of tyranny and oppression. Her commerce and wealth were so completely destroyed that she has never regained her former position as the leader of commerce and as a seafaring center. Today she is a large and rich city, with magnificent docks and wharves, with an extensive commerce and trade, but far behind London, Liverpool, Hamburg and other European seaports.

The distance from Antwerp to Rotterdam is so short that we were hardly sensible of the fact that we had left the suburbs of the former before we were crossing the Rhine to enter the latter city. The intervening country is in keeping with the greater portion of Holland, a low, flat land cut into numerous strips by ditches and canals, and reclaimed from the sea by numerous dykes. The land is too low and swampy for crops of wheat, rye and oats, but rich in grass, suitable for hay or pasturage. The Dutch farmer is, therefore, by necessity a dairyman and in this occupation he excels, the butter and cheese of Holland having the highest standing throughout the entire world.

Rotterdam is a large and wealthy seaport with extensive harbors, docks and wharfage, which are crowded with steamers and ships trading with countries all over the world. The city is so cut up with canals that it is almost disconnected by its waterways, which take the place of streets. Rows of vessels line many of its thoroughfares, with drawbridges connecting its many separated sections. "Water everywhere without a drop to drink" was an observation made by a passenger on our train. This seemed literally true not only of the whole of Holland but of nearly every place we visited in Europe. On the railroad cars no water fit to drink can be had. It is an unknown luxury in Europe. I did not see a single ice cooler in a railroad car, depot, hotel or public building in Europe, nor in a single place of business. It was next to impossible even to buy ice water in the hotels. I confess I paid more for ice water than for all other drinks, and I suffered more from thirst than from any other discomfort. People who drink only wine, beer, ale and bad water know none of the pleasures that come to one who drinks only pure ice cold water. Rotterdam is known best as the place where Holland gin is distilled and I presume its people drink gin as a substitute for water, as the Germans drink beer and the French wine. As an American I prefer pure ice water. The ride from Rotterdam to The Hague is through a low, flat country intersected with numerous ditches and canals and used almost entirely for pasture. The herds of beautiful cows we saw would make an American dairyman covetous.

We reached The Hague about noon and were driven to the Hotel Belmont, where we found most comfortable accommodations. The clerks, waiters and employes in this hotel speak English so well that it is chiefly patronized by those who speak the English language. After lunch we began our usual tour of inspection and saw the larger portion of the city before we retired for the night.

The Hague is a city of over 250,000 people. As the capital of Holland it is the most fashionable city in that country. It is said the Dutch people make their money in other localities and spend it at The Hague. The older sections of the city are ugly and quaint; the modern sections are handsomely built up. The Hague is built on very low ground and is cut up with the usual Dutch canal and ditch. It is located in a dense forest once owned by the counts of Holland. These forests still stand as a great park with their old trees and ditches around which the city has been built.

The palace of the Queen, known as the Palace in the Woods, erected before Columbus discovered America, stands in the middle of this great park. The house, built of brick, is large but a very plain structure exteriorally. Upon the payment of 25 cents we were conducted through the building by a woman guide who spoke indifferent English. The various rooms are very handsome and are furnished most beautifully with antique chairs, tables, bric-a-brac and tapestries.

Two rooms, one furnished by a former Emperor of Japan, and the other by an Emperor of

China, contain the most beautiful porcelain and chinaware I have ever seen, with other works of art, showing the great artistic workmanship of these people. In the center of the palace is a large circular room crowned with a dome. On the walls and dome is an allegorical painting representing the birth, infancy, childhood and manhood of one of the former kings of Holland. This great painting was made over 300 years ago by Dutch artists who were the pupils of Rembrandt and Rubens. It was stated by the guide that some six painters were employed for seven years in doing this work. It was so well done that today it looks as fresh as if it had been made only a few years ago. Just prior to this time Flemish art had reached its highest plane of perfection and rivaled the Italian school. In the museum at The Hague we saw the beautiful works painted by Rembrandt, Rubens, Van Dyck and many others which today are fresh and perfect, untarnished by the hand of Time. The First Dissection, by Rembrandt, 7 by 9 feet, hangs on the wall where it was probably placed over three centuries ago. The picture is so natural and life-like that all the characters stand before the eye, as living beings almost in the act of expressing their admiration and astonishment to the teacher, who is pointing out the anatomy of the arm which he is dissecting. The cadaver stretched before the pupils loses its ghastly expression in the intense interest which animates the countenances of those who stand around and take in the tissues laid bare by the knife of the anatomist.

This art museum in The Hague is devoted entirely to Flemish art. It is very rich in the work of the old masters and in examples which are unrivaled in any section of the world. The genius, versatility and industry of these old artists are fully illustrated in the extent, beauty and variety of works still in perfect state of preservation. The privilege of seeing these old masters will fully repay one for a visit to The Hague. There are, however, other objects of interest there which cannot fail to interest the student of history. In one of the public squares is a bronze statue of William of Orange, of heroic size, erected by the people of Holland to the memory of the great man who founded the Dutch Republic. No character in the world's history stands out in bolder relief than William of Orange. What Washington was to our country, William was to Holland and Belgium. But far more, the principles for which he labored and died have been of greater value to mankind at large than the mere founding of these two prosperous kingdoms. He resisted the tyranny of the bigot and taught the world to recognize that liberty of conscience and love of truth are the foundation stones on which alone man can build a character of faith and righteousness and hope of eternal life.

On Sunday afternoon we visited Scheveneng, which is some three miles from The Hague. It is located on the North Sea and is the great seaside resort for the people of Holland. It is handsomely built up with large and imposing hotels, and boarding houses, which are filled during the bathing season with thousands of visitors. The beach is a very low and sandy strip of land well adapted for bathing purposes. At the time of our trip there were thousands of people enjoying the surf and eating in the many cafés and eating-houses along the shore. Whilst Scheveneng is a very attractive place, it is not so large and handsomely built up as is Coney Island or Atlantic City.

The Hague has within recent years come into great prominence as the place where the International Peace Congresses are held. A magnificent marble structure is now in course of construction for the use of the Peace Congress, a gift of Mr. Andrew Carnegie to the cause of peace throughout the world. Great good must come to all nations from the work of the men who are delegated to these Congresses by the great nations of Europe and by our own country. Let us rejoice in the day when nations will cease to war with each other, when all differences will be arbitrated and settled out of the court of legal murder and bloodshed.

We deeply regretted our inability to visit the great University of Leyden, only some 13 miles from The Hague. This great school of learning has a most interesting history. During the struggles of Holland with Spain, the City of Leyden was besieged by the Spanish Army. Its people put up a long and brave resistance and withstood the pangs of starvation until reduced to a point where further resistance seemed impossible. Food could not be introduced and outside aid was despaired of. William of Orange, the leader of the forces of Holland, suggested to the landowners and burgomasters of many of the smaller cities that the only way to relieve the siege was to open the dykes and turn the North Sea into the low-

lands. This meant a total destruction of crops and inundation of many homes and towns, an enormous loss to his country. With an unselfishness which at all times had prompted the Dutch in the war with Spain, the dykes were opened, the land was flooded and the Spanish troops were forced to give up the siege or be drowned like rats in their camps. The Spanish commander, in ordering a retreat, said he could fight men but not the North Sea. The siege was raised and Leyden escaped the murder and desolation which had been inflicted by Spanish troops on other cities which had to surrender to their brutality. In honor of this great achievement and in commemoration of so great an event William of Orange proposed that a great university be endowed by the people of Holland. A charter was obtained, money was contributed by an impoverished people and the University of Leyden was founded in the year 1574. From that day to the present time it has been one of the great universities of the world. When we consider the heroism, unselfishness and intelligence of the Dutch people of that day we are not surprised to see that their descendants of our times are among the most cultivated and prosperous people of the world.

There is so much to interest one in Holland that I would have gladly lingered longer in that country. We were compelled to live up to our schedule as we were booked to leave on the steamer for home on the following Saturday. Monday morning we took the train at 9 o'clock for Hamburg, a ride of over 13 hours. Our way led through Harlem, Amsterdam and other smaller cities, along the Zuyder Sea for many miles until we reached the higher lands of East Holland. The railroad bed was over a low land across numerous canals and along the borders of the great dyke which keeps the waters of the sea from flooding a large section of Holland. As our car passed along the site of the great dyke we could see sailing vessels on the sea lifted many feet above the window presenting a most unusual but an attractive picture. For many miles we followed the sea walled in by human labor and forced back from the lands which at one time made its bed where thousands of cattle are now grazing. It is said the people of Holland have spent over $1,500,000,000 on its dykes and that the annual expense of maintaining these dykes is over $2,000,000. As large as these figures appear to be the land recovered from the sea and brought into use has more than repaid for the outlay.

In a country so densely populated as Holland (some 400 to the square mile), every acre of ground has a value and must be made to yield profitable returns. This would seem to be the case, for the Dutch farmer is a prosperous and well-to-do man—industrious, painstaking and up-to-date in management of his land.

The Dutch people are proud of their heritage and devoted to their country. By toil and skill they have made a great lowland, half marsh, half swamp, one of the most prosperous sections of the world.

The eastern section of Holland through which we passed is elevated and somewhat rolling, and here wheat, rye, oats, potatoes and beets are largely cultivated. I saw few fruit trees or orchards from the car window. As we were traveling toward the border line of Germany the conductor on the train, in answer to our questions, became very communicative and pointed out a number of interesting objects. He spoke fairly well Dutch, French, German and English, and explained to us that all of these languages were taught in the public schools of Holland and that railroad conductors were required to speak them on account of the enormous travel of foreign people over the railroads of Holland. As a conductor, a man of more than common intelligence, he received only one dollar a day. On this sum he supported a wife and four children and lived as he expressed it "well". The small wages paid railroad employees in Europe is in striking contrast with those received by the same class in this country. In spite of the fact that all the European countries are crowded with people and that much of the food supplies is brought from foreign countries the cost of living is much cheaper in Europe than here. This is due to the fact that the laboring and even well-to-do classes eat much less, are less wasteful and much better cooks. Earning much less, they save more and are more thrifty and I believe more contented than our people.

I was both pleased and disappointed with my ride through Germany. In some sections the farm lands are in a high state of cultivation and the country is very picturesque. In other sections the land is poor, barren and sparsely settled. It was after 10 o'clock at night when we arrived at the Atlantic Hotel in Hamburg. After a contin-

uous ride of 13 hours we were very tired and soon found rest in sleep.

The following morning we were joined by Rev. Dr. A. C. Rubenstein, of our city, who had crossed the Atlantic with us and had parted with us and journeyed on from London by another route. As he had secured rooms for us at the Berliner Hof we moved to that hotel and made it our headquarters during our stay in Hamburg. After breakfast we went to Thomas Cook & Son's for our mail and next to the offices of the Hamburg-American Line to arrange for our return passage. These two important matters attended to Mr. Page and I took a taxi to see the city. Hamburg is a city of over 900,000 people and one of the richest and most progressive cities in Europe. Next to London it has the largest tonnage of any seaport in the world. Located on the Elbe, 60 miles from the North Sea, its docks and shipbuilding companies are land-locked and secure from storms and tidal influence.

The number of steamships and sailing crafts coming to its harbor is so large that miles of wharves are needed for loading and unloading.

The Hamburg-American Line, owned by Hamburg capital, with its general offices in that city, has over 450 ocean steamers engaged in foreign trade. Not only in commerce but in all lines of business, insurance and banking, Hamburg does a very extensive work. The business section is built up in a most substantial way, but its beauty and wealth are best shown by its residential sections. The city is built around a large body of fresh water, known as Lake Austen, which averages one mile in width and some five miles in length. A broad avenue surrounds this lake, and fronting on this avenue are the most palatial business and private buildings I saw in Europe. The homes of the people of wealth fronting on this avenue are of the most attractive designs and ornamentation. They set back in yards filled with flowers and shrubbery, with porches and windows concealed by the rambler rose, climbing vines, geraniums and blooming flowers of every description. The effect of this wealth of floral decoration is very striking to one who lives in a city where flowers are seldom found except in parks and backyards.

There is one enterprise in Hamburg which must be seen to be appreciated. This is Hagenback's Zoological Gardens. In a park of over 50 acres this enterprising man has collected wild animals from almost every section of the world and has placed them within large enclosures where the natural habits of the animal are maintained as nearly as possible.

Lions, tigers, bears and wildcats live in caves and dens; seals and polar bears in water and on rocky cliff, representing huge icebergs; goats and mountain sheep climbing over large cliffs made of artificial stone. In these various homes there are animals bred in captivity and are then domesticated as much as is possible. The Hagenback Gardens draw thousands of people to Hamburg. It has done more to advertise the city than the immense harbor with its extended commerce.

Wednesday afternoon Mr. Page and I took the train for Berlin which is about 180 miles south of Hamburg. The distance was covered in nearly three hours' time. The railroad passed through a level farming country and on a smooth bed the locomotive made nearly 60 miles an hour. We reached Berlin before dusk and found rooms in the Deutsche Hof, a small hotel but neat and cleanly. After dinner we secured a taxi and were carried over the city at fast speed for some hours. We saw a great deal of the city, brilliantly illuminated and in its gayest attire. The walks, parks, casinos, eating houses and places of amusement were filled with men, women and children. Berlin is a very handsome city, more modern in its buildings than London or Paris. Its streets, parks and public buildings show the energy and enterprise of the German people. Its rapid growth in population since the Franco-German War is only an illustration of the great progress the German Empire is now making in increase of population and wealth. The thrift, industry and intelligence of the German people are shown on every hand and one has only to visit their country to realize its national strength.

On Thursday morning we made a hurried visit to Potsdam, some 20 miles from Berlin. This attractive old place was the residence of Frederick William and of his son, Frederick the Great, the two great rulers who laid the foundation of Prussia and of the German Empire. Frederick William will be remembered in history as the eccentric and parsimonious king who had a peculiar fancy for tall soldiers and for a full treasury. He organized the best disciplined army in Europe and accumulated large sums of money by his frugal habits of administration. After his death, Frederick the Great, found both men and money at his command, and to make himself notorious, as

he expressed it, waged war against Maria Teresa of Austria to recover Silesia. This led to the first, second and third Silesian wars, the latter of which lasted seven years and came near costing Frederick his life and kingdom. Austria, France, Russia and a number of the German states formed a coalition against Prussia; 100,000,000 people were arrayed against 5,000,000 Prussians. In the unequal contest Frederick was driven from pillar to post and almost vanquished. With a nerve and genius few men have ever possessed he came out a victor with his country ruined in fortune, but renowned in military prestige. The kingdom of Prussia then came into the front rank among the powers of Europe. Frederick William and Frederick the Great, his son, lie side by side in granite vaults in the old church erected by the former at Potsdam. The old buildings at Potsdam are but shadows of a former glory which remind the visitor of the changes which time makes in the affairs of men and of nations. Sans Souci, the residence of the present Emperor, is located in a large park adjacent to Potsdam. We were driven all through the grounds and saw the residence of the Emperor with its gardens, orchards, hot houses and stables. The palace is large but not pretty. It might be mistaken for an asylum if one was not informed as to its true character. The most beautiful object we saw was a small chapel in which lie the tombs of "Unser" Fritz and his wife, Victoria, father and mother of the present Emperor. Over each tomb is a recumbent figure cut out of purest white marble, lifelike effigies of the deceased.

Thursday evening we returned to Hamburg and Friday was given up to further sightseeing in that city. At 8 o'clock Saturday morning we took a train for Cuxhaven, 60 miles distant, where we stepped on board the steamer Pennsylvania for our return home. With the band playing and a large crowd of people on board exchanging farewells the steamer quietly moved away from the landing and was soon moving westward. To say that I was glad to be homeward bound only half expresses my feelings. The voyage across the Atlantic was a long and tiresome one to me. The steamer was crowded with passengers and the discomforts were many.

It was a German steamer with German cooking. This was too much for me. I could scarcely eat the food and could only drink the water by taking an acid in my mouth to disguise the taste. To compel the passengers to buy beer, wine or poor lemonade the company provided no suitable water. I suffered from thirst the entire trip. No more German steamers for me should I ever visit Europe again.

My friend, Dr. Randolph Winslow, has advised the readers of THE BULLETIN to see America first. I saw a good deal of America before I visited Europe, so my advice is to see both countries. The man who sees America first will come back from Europe with a keener appreciation of his own country than he has ever had. Europe is an old country filled with history and monuments of human greatness. We owe much to the people who have made our civilization so rich in all that ennobles and elevates mankind. We all sprang from European soil and should feel that reverence which every child should have for parental training and affection. We have learned much and have much more to learn from our European kindred.

When the steamer on which we returned landed at the wharf in the harbor of New York I was truly happy to be again on American soil. After passing the inspection of the custom house officials where the greatest courtesy was extended, I secured a ticket for Baltimore over the Pennsylvania Railroad, and reached my home at 5.30 in the afternoon. We were absent from home 48 days. During this time we traveled by water and rail about 10,000 miles. We visited England, France, Switzerland, Belgium, Holland and Germany. We enjoyed almost perfect health, escaped accident and delay, had great satisfaction and profitable experience, and returned to our homes with our hearts full of love for our own country and our own people.

A large and successful subscription card party was held on Wednesday, November 29, at the Hotel Emerson for the benefit of the University Hospital. The affair was arranged by the Ladies Auxiliary, and the proceeds donated to be used in the free wards of the Hospital. The committee on arrangement was Mrs. Frank Martin, Mrs. L. Ernest Neale and Mrs. William Kelso White. Among those who assisted were Mesdames Hamilton Easter, Joseph Holland, John C. Hemmeter, Francis E. Waters, Samuel C. Chew, William H. Matthai, John K. Shaw, Jr.; Misses Florence P. Stieff and Lucy Marshall.

SEE AMERICA FIRST.

By Randolph Winslow.

4. SAN FRANCISCO AND THE BAYSIDE CITIES. THE COAST LINE TRIP BACK TO LOS ANGELES. ACROSS DESERT TO SALT LAKE CITY.

My first visit to San Francisco was in August, 1905, about ten months before its desolation by earthquake and fire; hence my chief curiosity on this visit was to see how much it had recovered from its great catastrophe, and to note the changes in the character and appearance of the reconstructed city. Enormous progress has been made in rebuilding the city; and the new buildings are much more imposing than the old, and are built of ferro-concrete material, hence are supposed to be both fire and quake proof. The city as a whole, however, has lost much of its oriental and foreign appearance, and does not differ materially from other modern American cities. Chinatown has been reconstructed on its old location, but it also does not possess the air of mystery as in the old days, and the company houses are better built and less insanitary than before the fire. Thousands of Chinese live and labor in this locality, and have their small shops and places of business here. The Sing Fat Company and the Sing Chong Company have huge stores where one can buy almost any product of the Orient, at a reasonable figure. Chinatown is of quite restricted area, being about three by six blocks in extent, but housing many thousands of Chinese men, women and children, many of whom live in cellars and other unsanitary places. The situation of San Francisco is remarkable; with its front in the Bay, it extends about five miles over steep hills to the Pacific Ocean, and is bounded on the north by the narrow and deep Golden Gate, which connects the Ocean with the Bay. All the commerce of the city passes through the Golden Gate to the docks and wharves on the bay side, while the broad Pacific beach affords a splendid seaside resort right at its back door. The Cliff House, Sutro Baths, Golden Gate Park and the Presidio, the United States Army reservation, are all found overlooking the Western sea. In no respect has the resurrection of San Francisco been more marvelous than in its large and fine hotels. The magnificent white pile of the Fairmont Hotel crowns Nobs Hill, and is visible from afar. St. Francis Hotel, in Union Square Plaza, is also a splendid hostelry, as is the Palace and many others. As I had on my previous visit explored the city pretty thoroughly, I did not spend much time in repeating my former experiences, but instead visited the towns on the other side of the Bay. Incidentally I may say that the weather was raw, damp and cold, and though the temperature in the east was over 100 degrees, and deaths from sunstroke were numerous even in New York and Boston, here overcoats were worn with comfort and even fur coats were not an unusual sight. On the other side of the Bay, the sky was clear, the air balmy and the weather like that of spring.

In the hollow of this tree, in the Calaveras Grove, a hunter and guide lived for nearly three years. It was his "roof tree." It is a one-roomed cabin, is 16x21 feet, and was sometimes shared with his horses. The "simple life," and no rent to pay!

Crossing to Berkeley, we seemed to be in a different country, the streets were lined with solid banks of brilliant colored flowers, and as far as one could see there were double rows of geraniums and other flowering plants. The bungalows and cottages, each with its separate lawn and grounds, flowers and vines, added beauty to the scene. At one place were a number of rocks hollowed into bowls by the Indians and evidently used at one time for grinding grain and acorns. The University of California is located at Berkeley in a large

reservation of about 600 acres. There are at present about 50 buildings that are sufficiently fine, but are considered as temporary and will be replaced by other more elaborate structures. The student body numbers 3500, male and female.

Berkeley and Oakland are directly continuous cities but are separate municipalities, as is Alameda, which adjoins Oakland on the south. The population of Berkeley is 35,000, Oakland 150,000, Alameda 25,000, and Piedmont 3000, hence the combined population of these towns on the eastern shore is about one-half of that of San Francisco, directly opposite. They do not wish to be considered as the overflow of the more noted city, but as separate and independent centers of trade and commerce. The calamity of San Francisco was the opportunity of these towns; but while the former has more than regained her previous population, the east side towns have held their own and are increasing at an enormous rate. Oakland is an especially hustling city. It is engaged in many civic improvements, such as reclaiming a large area of water frontage by filling up the shallows of the bay; the enlargement of the harbor, erection of public buildings and the improvement of the streets. Who has not heard of Twenty Mule Team Borax, and who has not seen fabulous looking pictures of the twenty mule teams hauling huge wagons filled with borax from the dusty desert? This is, however, no fable, and the facts were as depicted. A man named Smith, and now known as Borax Smith, discovered the deposits of almost pure borax in Death Valley, and has made an enormous fortune therefrom. He has a magnificent residence in Oakland, which is one of its show places. At both Los Angeles and Oakland there are ostrich farms where the birds are bred for their plumage. The ostrich is an ungainly bird, of not very amiable disposition, which renders it unsafe for one to attempt any familiarities. In one respect at least they are said to differ from human beings; they are monogamous and mate but once. The little town of Piedmont is also a very active place, and, though a new settlement, has a fine park and an art gallery containing many masterpieces of painting, of which any city might be proud. Alameda is situated on an island separated from Oakland by an estuary, and is a fine residential town, with a beautiful water front and streets lined with fine shade trees. In the opinion of the writer any of these east side towns are much more desirable as places of residence than is San Francisco. On July 6 we again took to our special train on the Coast Line of the Southern Pacific Railroad. Leaving the metropolis, we skirted the western shore of the Bay, passing through Palo Alto, the home of Leland Stanford, Jr., University, the tops of whose buildings could be seen in the distance, and thence over a rather steep mountain range to the Big Trees near Santa Cruz. This is a grove of giant redwoods—sequoia sempervirens—some of them over 300 feet tall and from 55 to 65 feet in circumference. The trees are named after distinguished persons, as General Grant, General Sherman, President Roosevelt and others, or are designated by names indicating their characteristics, as the Giant, Jumbo and the Cathedral. They are sup-

BUNGALOWS IN WINTER, MIRAMAR, CAL.

posed to be from 4000 to 5000 years old, and many of them have become hollow, and frequently the interior has been eaten out by fire, which, however, is said to preserve them. They rise straight in the air for 100 feet before giving off a branch, and then the branches are numerous and the foliage abundant. They are coniferous trees with cones resembling those of the ordinary pine. Many persons could take refuge in one of these hollow trees in case of stress, and find protection from the storm. Six miles from the Big Trees is Santa Cruz, the "Atlantic City of the Pacific Coast," which is San Francisco's most popular seaside resort. We now ran along the shore of Monterey Bay to Del Monte, where is the celebrated hotel of the same name. This magnificent and commodious hotel is surrounded by beautiful grounds in which are a profusion of brilliant flowers and rare plants and trees. One would willingly linger longer at this lovely place, but our time was limited. The old city of Monterey, the first Spanish capital of California, is nearby. Here is the old San Carlos Mission, redolent with memories of Fra Junipero Serra, the pious monk who did so much to plant the cross and civilize the natives of this portion of the Western Coast. Fish are so plentiful here that they are caught by letting down unbaited hooks and allowing them to become impaled on the hooks. A beautiful drive along the shore is especially interesting on account of the large number of cypress trees, often of grotesque form, and either lying flat on the ground or greatly inclined. I presume it must be due to the push of prevailing winds, though pine trees in the same locality are straight. The ostrich tree is especially grotesque and at a distance resembles this huge bird. Leaving Del Monte our next stop was at Paso Robles Hot Springs, where there are stinking sulphur springs that are supposed to be beneficial for gouty and rheumatic conditions. The smell was enough for me, and I did not desire any closer acquaintance with the water, either internally or externally, though some of the party went into the swimming pool and were considerably depressed thereby. Early in the morning of July 8 our train was stopped at Point Concepcion to allow us to see the wreck of the steamship Santa Rosa, which had gone ashore in a fog the previous day, and had broken in half. One hears of shipwrecks and the

"GEN. GRANT" BIG-TREE GROVE, SANTA CRUZ, CAL.

breaking of the ship, but it is not often that one has the opportunity to see such a disaster from a safe and near-at-hand point of view. The ship did not seem to be more than a few hundred yards away, and many of the castaways were still encamped on the beach awaiting transportation. Pursuing our journey we reached Santa Barbara, where we spent the rest of the day. While Santa Barbara is not a very handsome town, it is attractive. It fronts on a crescentic bay and has a fine beach. There are fine hotels, especially the Potter and the Arlington. The climate is delightful and the bathing good. The Santa Barbara Mission is located here and is the best preserved of the Spanish missions. Monks who wear brown gowns fastened with a rope around the waist, and sandals on the feet, guide you through the building and grounds. Incidentally they sell curios

and relics of various kinds. From Santa Barbara we journeyed back to Los Angeles in the night, switched to the San Pedro, Los Angeles and Salt Lake Railroad, and began our return trip across the continent. Our immediate destination was Salt Lake City, 781 miles distant from Los Angeles. All day July 9 we traveled across the desert of Lower California and Nevada. The country was barren, the soil alkaline, vegetation scant, and water scarce except when pumped from artesian wells. The towns were few and far between and were of the typical Western style, rendered famous by Frederick Remington and others. Frame shacks with high fronts and possibly a porch, mostly devoted to rum selling and gambling. The temperature was 120 degrees in the shade and like the blast of a furnace, but as a matter of fact there was no shade except in the unshaded houses. At one of the wayside stations I spoke to a rather rough looking man sitting on a box, who said he had come from Baltimore and had been living in the desert for eight years and liked it very well. He said he kept a livery stable and also had a ranch. I did not think there would be any demand for teams in such a forlorn country, but he said he had sent out two that morning. In the evening we reached a better country and crossed a mountain range, and early the next morning were running along the southern shore of the Great Salt Lake and arrived at the Mormon capital about 8 o'clock.

ECHINOCOCCUS CYST OF LIVER—SYMPTOMS AND SURGICAL TREATMENT.

By B. J. Asper,
Senior Medical Student.

The tenia echinococcus, in its adult form, occurs in the upper part of the intestine of the dog, less commonly of the wolf and jackal. The mature worm is from 2.5 to 5 mm. in length, and consists of four segments. The first segment, or head, is provided with four suckers and a rostellum bearing from two to four dozen hooklets in a double row. The second segment is somewhat smaller, and the third considerably larger than the head. The fourth is the largest of all, constituting from one-half to two-thirds of the entire worm. It is in this segment that the uterus of the parasite is situated, this uterus consisting of a median portion with a few lateral branches, and containing about 5000 eggs.

These eggs, deposited usually in water or on vegetables, or conveyed by tactile communication from the body of the lower animal serving as their host, reach the mouth of man. In the stomach or intestines the embryo is liberated by the solution of the egg capsule by the action of the digestive juices, bores its way through the mucous membrane of these portions of the digestive tract, thus reaching the blood and lymphatic stream, and transported thereby to the liver and various other organs, where it develops an echinococcus cyst. Once having reached its destination in the liver, it undergoes the following changes: The hooklets disappear and the embryo is gradually converted into a small cyst, which presents two distinct layers, an outer cuticular and an inner parenchymatous or granular-cellular layer, the whole being surrounded by a capsule of fibrous tissue.

As the cyst develops there appears therein a clear limpid fluid, non-albuminous, and of low specific gravity (1009 to 1015). Hooklets are to be found in this fluid in a large majority of cases, and are of considerable diagnostic value.

Such a cyst may increase in size without any alteration in its general structure. More commonly, however, when the primary cyst has attained a certain size, buds develop from the inner parenchymatous layer, which are gradually converted into cysts which are identical in structure with the original cyst. These secondary or daughter cysts may project either inwardly or outwardly, and are soon set free from the mother cyst. In this way the parent cyst as it grows may contain a dozen or more daughter cysts. Inside of these daughter cysts a similar process may occur, and from the buds in the walls granddaughter cysts are developed.

Another form is the multilocular echinococcus cysts, in which the primary cyst buds develop and are then cut off completely and are surrounded by thick capsules of connective tissue, which join together and ultimately form a hard mass represented by strands of connective tissue, enclosing alveolar spaces about the size of peas.

It is not known definitely how long the echinococcus remains alive, probably many years, possibly as long as 20 years. During all this time the

cyst may continue to grow until it has reached an enormous size, without secondary changes. The most common change is death of the parasite and the gradual inspissation of the contents of the cyst, so that it becomes converted into a mass of putty-like material, which may be partially calcified. A more serious termination is rupture, which may take place into a serous sac, or perforation may take place into the bronchi, alimentary canal or urinary passages, when the contents of the cysts are discharged externally. Most unfavorable are the instances of rupture into the superior vena cava. A third and very serious mode of termination is suppuration, which may occur spontaneously or following rupture.

The symptoms of echinococcus cyst of the liver, in the absence of any of the complications referred to above, are entirely mechanical, and are due only to the pressure or weight of the tumor. Indeed, small cysts may cause no disturbance. The larger cysts are accompanied by feelings of pressure or dragging in the hepatic region, sometimes with actual pain. The general condition of the patient remains for a long time good, and the nutrition is little, if any, interfered with. The large and growing cysts produce signs of tumor of the liver, with a great increase in the size of the organ. The physical signs naturally depend much upon the situation of the growth, near the anterior surface in the epigastric region, the tumor may form a distinct prominence and have a tense, firm feeling, sometimes with fluctuation. A rather common situation is to the left of the suspensory ligament, the resulting tumor causing upward displacement of the heart and an extensive area of dullness in the lower sternal and left hypochondriac regions. In the right lobe, if the tumor is on the posterior surface, the enlargement of the organ is chiefly upward into the pleura, and the vertical area of liver dullness in the posterior axillary line is increased. Superficial cysts may give the so-called "Hydatid Tremilus." The tumor is palpated lightly with the fingers of the left hand, and percussed at the same time with those of the right, when there is felt a vibration or trembling movement which persists for a certain time. This is not, however, constantly present, and it is doubtful if it is characteristic of hydatid tumors, as was once supposed.

When suppuration occurs the clinical picture is converted into one of rigors and sweats, with a greater or lesser amount of jaundice and rapid emaciation. Perforation may occur into any of the parts mentioned, and in rare instances recovery has taken place.

Treatment.—Although the existence of hydatids in the liver in the majority of cases is for a long time compatible with a fairly comfortable existence, and many medical authorities advise noninterference when there are no distressing symptoms, still the success of operative treatment has been so great that it is advisable, when hydatids have been diagnosed, to proceed at once to operation. Simple aspiration was formerly extensively employed, and was successful in many cases, but more recent authorities state that by this method of treatment the mother cyst has not been removed, and that relapses frequently occur, even after apparent cure, and since operative measures have proved so safe, most modern surgeons do not hesitate to recommend them. The operation may be performed in either one or two stages.

Operation in One Stage.—This is the more recently devised of the two operations, and has to a large extent supplanted the operation in two stages. All aseptic precautions having been taken, as in other abdominal operations, an incision is made over the most prominent part of the tumor down to the peritoneum. This is then carefully opened and the edges packed round with gauze. The tumor is incised, the contents evacuated and the edges of the cyst sewed to the abdominal wound, the gauze being withdrawn as the stitches are inserted. As suture material, either silk or catgut may be employed. A large drainage tube should be introduced into the cavity and the wound dressed aseptically. In cases where the cyst is covered by a considerable thickness of liver tissue, an aspirating needle should first be introduced to make sure of the character of the contents, the liver incised and a finger inserted through the opening to prevent hemorrhage, which can usually be controlled by sponge pressure. The edges of the opening in the liver should next be stitched to the abdominal wound, a large drain introduced into the cyst and sterile dressings applied. The stitches in the liver usually hold well.

Operation in Two Stages.—In this operation an incision is made along the lower margin of the ribs over the cyst down to the peritoneum. All bleeding having been arrested, the peritoneum is incised the entire length of the wound and the wound then dressed with iodoform gauze. Adhesions form between the parietal peritoneum and

that covering the tumor, which are usually quite firm in five or six days, when the tumor may be incised, the contents evacuated, the cavity irrigated and a drainage tube introduced. This operation has been very successful, and is even yet preferred by some surgeons.

The following textbooks were employed in the compilation of this article: Stengel's Pathology, Keen's Surgery, Osler's Practice, American Text-Book of Surgery.

HOOKWORM DISEASE IN ITS INFECTION RELATION TO THE WHITE AND COLORED RACE.*

By Charles Franklin Strosnider, M. D., '09.

Up to the present time very little work has been done in our Southern States in a given locality among both races which would give some idea of the relative infection with hookworm disease, the reason therefor being concisely given in a reply to an inquiry bearing on the subject in question by Dr. J. Y. Porter, State Health Officer of Florida, who says: "We have never seen any manifest evidence in the negro as in the white person, and have had all we can do looking after it where we could see it."

I beg to invite your attention to the following data (see page 193), which has been collected from different sections of North Carolina with a view to showing the percentage of negroes infected with hookworm disease as compared with the white race in the same school district of each county.

Dr. C. L. Pridgen and I have observed that where we have a rise in the infection among the whites we have a corresponding rise in the blacks, but always a much lower percentage.

Furthermore, I have observed that the infection is higher among the mulattoes than among the full-blooded African, as was the case in the following colored schools: Dudley, 67 per cent.; Shady Grove, 64 per cent.; Burgaw school, 55 per cent. The mulatto pupils in these schools are in the majority.

Suggestions bearing on the probable explanation for difference in percentage of infection:

1st. Toughness of the African's skin on the bottom of his foot may play some part, even though the majority of the negro pupils whom I lectured to last school session gave a ground itch history.

2d. Late rising in the morning. As a rule the negro youth does not rise early enough to be about during the time when the hookworm larvae are most active.

3d. The negro youth's dislike for mud and water. After rains the negro youth usually remains indoors, for the reason that they do no like to be in the mud or water. The majority of the negro homes sit out in the open, with few if any, shade trees near enough to serve the twofold purpose of relief and playgrounds. Therefore, the young negro remains indoors until the sun has performed the drying work, and the hookworm larvae, if any about, have sought protection beneath the surface soil.

4th. The general use of snuff and tobacco. It is well known that the negro race is an extensive user of tobacco in one form or another. Chewing tobacco and dipping snuff is begun in early youth. In either case frequent expectorations are necessary. Therefore, should the hookworm larvae come up into the pharynx and mouth its chances for being swallowed would be few as compared with those of being expectorated. Again, much of the nicotine is picked up by the system and some of the tobacco saliva is swallowed, which may work some hardship on the parasite.

5th. Pigment action. The pigment may have a repellant effect upon the hookworm larvae.

6th. Secretion by the skin. In view of the fact that the negro race and hookworm disease are old in acquaintance, it may be that an anti-hookworm substance is secreted by the glands of the skin of the full-blooded African, which would either lessen the activity, act as a repellant or destroy the larvae. After finding such a large percentage of young negroes giving a ground itch history and such a small percentage of the same pupils suffering with hookworm disease, I am led to believe that either the ground itch in the majority of the cases is brought about by another factor or is due

*Read before the North Carolina State Medical Society, in Charlotte, N. C., June 22, 1911.

to hookworm larvae, the same being killed at their initial point of attack or by the use of tobacco, or by a cause as yet not mentioned.

I am indebted to Dr. B. W. Page, District Director of Sanitation, Salisbury, N. C., for the following data from Rowan county:

		No. Exam.	Hookworm.	Per cent.	
Rowan County:					
Cleveland School	White.	31	7	22.5	
	Col.	31	2	6.4	

I am indebted to Dr. C. L. Pridged, District Director of Sanitation, Marion, S. C., for the following data:

Asheville, Buncombe County:					
Asheville Graded and High School	White.	933	117	12.5	Sewered.
	Col.	545	22	4	Sewered.

		Exam.	Infect.	Per cent. Hookworm.	
Burk County:					
Morganton Graded and High School	White.	328	161	49	Sewered.
	Col.	57	9	15.7	Sewered.
Oak Hill	White.	13	6	47	Rural.
Willow Hill	Col.	43	7	17	Rural.
McDowell County:					
Marion Graded and High School	White.	38	29	76	Sewered.
	Col.	75	22	31	Sewered.

The following data has been collected by the writer:

Wayne County, Brogden Township:					
Goldsboro Graded and High School	White.	180	36	20	Sewered.
	Col.	136	6	4.4	Sewered.
Mt. Olive Graded and High School	White.	160	101	63.1	Semi-rural.
	Col.	90	15	7	Semi-rural.
Dudley	White.	31	25	80.6	Rural.
	Col.	57	38	67	Rural.
Parker No. 2	White.	47	38	80.9	Rural.
Augusta No. 2	Col.	46	15	32.5	Rural.
Thunder Swamp	White.	39	21	53.8	Rural.
Shady Grove	Col.	25	16	64	Rural.
Glenwood	White.	20	20	100	Rural.
Davis Chapel	Col.	19	7	36.8	Rural.
Seven rural schools	White.	113	62	54.8	Rural.
	Col.	151	24	15.8	Rural.
Brunswick County:					
Southport Graded School	White.	31	5	161	Semi-rural.
	Col.	60	2	3.33	Semi-rural.
Pender County:					
Burgaw Graded School	White.	157	119	75.7	Semi-rural.
	Col.	51	28	55	Rural.
New Hanover County:					
Middle Sound	White.	9	7	78	Rural.
	Col.	26	10	38.4	Rural.
SEWERED STATISTICAL SUMMARY.					
White Pupils		1441	314	21.7	
Colored Pupils		738	37	5	
NON-SEWERED STATISTICAL SUMMARY.					
White Pupils		631	411	63.1	
Colored Pupils		599	164	27.4	

Surgeon Rupert Blue, class of 1892, of the United States Public Health and Marine Hospital Service, is being urged for appointment as head of that service, to fill the vacancy created by the death of Surgeon-General Walter Wyman.

A few weeks ago Dr. Blue was sent to Honolulu to assist in stamping out a yellow fever epidemic. He has been recalled to the United States since the death of Dr. Wyman.

Dr. Blue was born in North Carolina in 1867. After obtaining his diploma from the University of Virginia he was graduated in medicine from the University of Maryland in 1892. Immediately after finishing his medical course he was appointed to the Public Health and Marine Hospital Service, being promoted through the various grades to that of surgeon in 1909.

He has specialized in the study of yellow fever and bubonic plague. His work in New Orleans, San Francisco, Honolulu, Quito and other places ranks with that of the army specialists in Cuba and Panama. He was a delegate to the Immigration Medical Congress in Genoa in 1899.

In San Francisco his remarkable success was attributed to his discovery that the plague is carried by ground squirrels as well as by rats.

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, DECEMBER 15, 1911.

"MANY MICKLES MAKE A MUCKLE."

Unfortunately we have not been able to interest persons of large means, as yet, in the effort we are making to raise the $100,000 endowment fund for the Department of Pathology. We hope to have better success at some future time; in the meanwhile, however, we have not been idle, and though our efforts have not been rewarded as well as we might have desired, we are by no means discouraged. A number of circumstances have prevented our making as active a canvas as usual, and the sums contributed have been small. We are very grateful for these small contributions, for they usually mean a sacrifice on the part of the contributors, and we know that if we can get enough small contributions, the aggregate will be large. Remember the adage quoted above, and do not hesitate to contribute small sums if you are unable to give larger ones. The subscriptions to December 1 are as follows:

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Terra Mariae, 1911	3.50
Total	$9030.50

Additions for month, $328.50.

ABSTRACT

Dr. John Rawson Pennington, class of 1887, of 4613 Winthrop avenue, Chicago, Ill., in a paper upon "Cancer of the Rectum," read before the last meeting of the American Proctological Society, writes:

"I take it we are all agreed as to the increasing frequency of cancer. At least it seems to me no other conclusion can be drawn from the following figures: According to the twelfth U. S. census cancer appears to have increased 12.1 deaths per 100,000 population in the previous decade. In Great Britain, so we learn from the work of Roger Williams, the deaths from cancer increased from 177 per million in 1840 to 885 per million living in 1905. Williams points out that while the population barely doubled from 1850 to 1905, the mortality from cancer increased more than sixfold. Nor is the increase confined to the United States and Europe; it holds good for Japan, India, and even for uncivilized countries. In short, cancer is one of the several diseases which is apparently increasing by leaps and bounds, in spite of our boasted progress in medicine, surgery and hygiene. Apart from the increased prevalence, the present death rate from malignant diseases is something dreadful to contemplate. Our anxiety in regard to malignant disease of the rectum is pardonable when we reflect that a good proportion of cancers involve this region. Williams found that 9.6 per cent. in males and 5.3 per cent. in females were located in the rectum. Is there anything that can be done to check this foe? The writer believes there is, and that this society may be made a powerful factor for good in such a crusade. In Germany a similar crusade has been started against cancer of the uterus by Winters, agitating the subject both among the profession and the laity. It is estimated that the number of cases of inoperable cancer of this organ has been reduced over 30 per cent. as a result of calling attention to the early symptoms. Of the 2914 cases of rectal cancer in the male referred to by Williams, 2592 patients were over 45 years of age and 2180 of the 2533 female patients In the male sex, again, the average age at which the onset was noted was 49.7 years, the minimum being 16.75 and the maximum 74, while in the female sex the average was 50.4 years, with a minimum of 21.8 and a maximum of 88 years. This brings me to the crux of my argument, that every person who has reached the so-called 'cancerous age' should be examined periodically for evidence of commencing carcinoma, not necessarily of the rectum alone, but in the female, for example, of the uterus also.

"In 120 resections of the rectum for malignant disease W. J. Mayo observes: 'It is an unfortu-

nate fact that in the majority cancer of the rectum is not recognized in time to obtain a radical cure.' I said a moment ago that cancer in the beginning is a local disease. This granted, then early and thorough removal must lead to a cure. It has been shown that a large proportion of malignant growths originate in scar tissue. In cancer of the stomach, for example, the Mayos found that no less than 62 per cent. showed evidences of a previous ulcer. In rectal cancer patients frequently give a history of previous operations on the part. Does the cancer occur in the scar left from an operation for hemorrhoids done by one of the commoner methods, ligature, clamp and cautery, or some other technic leaving much scar tissue and sometimes stricture? May it not be occasionally engrafted on the scar following the usual incision method of operating for fistula? Here is a suggestion for us in our own work: Secure smooth healing by resorting only to such procedures as leave the minimum of cicatricial tissue, hence the least possible nidus for possible mischief in the future. With the co-operation of the public it seems to me we should learn much about cancer in the early stages. To educate the public we must, as has been well said, 'organize, systematize, deputize, energize, supervise and economize,' The field is broad and the opportunity is at hand. Shall we grasp it?"

ITEMS

Dr. Henry Wheeler McComas, class of 1888, of Oakland, Md., in a recent interview in the Baltimore *Sun,* deplores the entrance of the physician into the political field, feeling that "it is true, unfortunately, that in almost every county physicians are either candidates for high offices, which take up a large share of their time, or are regarded by the party workers as the principal vote-getters on their lists.

"I have been mayor of Oakland several terms, but I shall never again be a candidate, for the reason that I do not conceive it to be right for physicians to mix in affairs of government, however simple.

"The practitioner of medicine should keep out of politics, just as carefully as members of that higher profession who wear the 'cloth.'

"Physicians playing politics can not find the time necessary for the proper care of their patients. They reach a state of stagnation. It is well known, too, that the physician who does not read and keep abreast of the thought of his time cannot do justice to his clientele, or make any progress that is worth while."

Dr. Henry W. McComas is a son of Dr. Josiah Lee McComas, a member of the class of 1858, and now 87 years of age. Dr. Henry McComas has been practicinig for over 27 years in Western Maryland, and for many years conducted the first hospital in Garret county. He possesses the unique distinction of having four sons studying medicine, and three daughters in training as nurses.

Callender F. Winslow, son of Prof. Randolph Winslow, who was recently operated upon at the University Hospital for appendicitis, has sufficiently recovered to return to his home.

Dr. Clifton Norwood De Vilbiss, class of 1910, assistant resident surgeon in the University Hospital, is a patient there.

Dr. Norman Thomas Kirk, class of 1910, of Rocky Mount, N. C., was a recent visitor to the University Hospital.

The Phi Sigma Kappa fraternity has removed from 1004 McCulloh street to 816 Park avenue. They held their housewarming on the evening of November 17, 1911.

Colonel Louis Mervin Maus, M. D., class of 1874, surgeon United States Army, has written a book, "An Army Officer on Leave in Japan," which has been published by A. C. McClurg Company, 1911. The book is most favorably reviewed in the Military Surgeon for December, 1911. We wish Colonel Maus much success with this work. In it he appears as a Mr. Rhodes, who holds an important position in the National Bureau of Commerce, and who hurriedly tours the Orient. He visits Manila, thence to Japan via the usual Army route, landing at Nagasaki, and traveling as far north as Nikko. Chapters are introduced on the religion, customs, the recent war with Russia, the origin and history of the Japanese people, also notes on hotels, guides, richshas and rail-

roads. The book is a valuable guide-book to Japan, and highly interesting. We wish that the author would send a copy to the University Library. Altogether, the record of the University of Maryland men in the United States service is rather enviable.

At the last meeting of the University of Maryland Medical Society, held in the hospital amphitheatre Tuesday, November 21, 1911, Dr. Robert Parke Bay, class of 1905, was elected president for the ensuing year; Dr. C. W. McElfresh, class of 1889, vice president, and Dr. Arthur Louis Felsenfeld, class of 1909, secretary.

We are anxious to secure three copies of the April, 1911, BULLETIN, containing Dr. John C. Hemmeter's article on "Henry R. Carter—A Pathfinder in the Etiology and Prophylaxis of Yellow Fever," and will thank any of our readers who can supply us with this issue.

Dr. Henry A. Naylor, class of 1900, of Pikesville, Md., who was recently operated upon at the University Hospital for appendicitis, is rapidly recovering.

Dr. William E. E. Tyson, class of 1905, is anxious to know if Dr. Mitchell still remembers his full name. Dr. Tyson has built up a splendid practice in Detroit.

We regret to announce that our good friend, Dr. Eugene Fauntleroy Cordell, has been ill recently, and are glad that we can state that he is now convalescent.

Among the recent visitors to the University Hospital were Drs. Norman Heggie, class of 1902, of Jacksonville, Fla., now fully recovered from his recent attack of typhoid fever; Louis Hamilton Seth, class of 1908, of McDaniels, Md.; Walter B. Kirk, class of 1893, of Darlington, Md., whose wife was for a time quite ill at the Hospital, but who is now sufficiently recovered to return to her home; Daniel Alvery Watkins, class of 1903, of Hagerstown, Md., and James Lee Hopkins, class of 1897, of Havre de Grace, Md.

Dr. George Yellot Massenburg, class of 1911, who was ill with typhoid fever, has recovered sufficiently to return to his duties at the Church Home and Infirmary.

Dr. Albert Hyson Carroll, class of 1907, is now located at 906 N. Calvert street.

Dr. Eugene Bascom Wright, class of 1909, was recently appointed superintendent of the Church Home and Infirmary, vice Dr. Don Preston Peters, resigned. Dr. Wright was formerly assistant superintendent at the same hospital. We wish him the highest success in his work.

Dr. Lester J. Efrid, class of 1903, in partnership with Drs. J. B. S. Holmes and R. M. Goss, announces the opening of "The Halcyon," a private sanatorium for surgical, gynecological, obstetrical and medical cases, at Tampa Bay Hotel Park, Tampa, Fla., and invites the physicians of the country to visit him there.

Dr. G. Timberlake, clinical professor of genito-urinary diseases, has been elected an honorary member of the Kanawha Medical Society of West Virginia.

Dr. J. B. Edwards, class of 1911, has removed from Wedgefield, S. C., to Saluda, S. C.

Dr. Edward Anderson, class of 1875, of Rockville, Md., has been reappointed physician to the almshouse of Montgomery county, Maryland.

The annual banquet of the General Alumni Association of the University of Maryland was held at the Rennert Hotel on the evening of Academic Day, November 13, 1911, at 8 P. M. The alumni were addressed by Prof. C. Alphonso Smith, Edgar Allan Poe Professor of the University of Virginia and Roosevelt Exchange Professor with the University of Berlin, and Messrs. J. Walter Lord and T. Scott Offutt of the Baltimore and

Towson bar, and by Mr. Carl Schon, entertainer. Governor Crothers and Mayor Preston had accepted invitations, but were unable to be present.

Professor Smith's address on American Literature was a masterpiece of after-dinner speaking. It was instructive and well worth a place in the lectures of a college, yet at all times brilliant and entertaining. His audience regretted when he ceased speaking, and we feel that the privilege of hearing his address was well worth the labor connected with the arrangement of the banquet.

The banquet committee were Mr. Frank V. Rhodes, chairman; Drs. B. Merrill Hopkinson, Nathan Winslow, and Messrs. John Henry Skeen and Henry P. Hynson.

The medical alumni present were Drs. Compton Riely, H. J. Maldeis, W. F. Sowers, Joseph E. Gichner, John C. Hemmeter, T. O. Heatwole, A. L. Wilkinson, H. M. Robinson, Irving J. Spear, Robert P. Bay, Howard W. Jones, H. C. Davis, John C. Uhler, J. T. O'Mara, A. H. Carroll, C. R. Winterson, J. W. Holland, B. M. Hopkinson, Arthur M. Shipley, A. L. Fehsenfeld, R. L. Mitchell, F. H. Vinup, I. H. Davis, S. Demarco, G. S. M. Kieffer, E. H. Kloman, Charles E. Sadtler, Hugh Brent, Eugene F. Cordell, J. D. Iglehart, J. M. Hundley, Samuel T. Earle, W. H. Smith, Nathan Winslow, Randolph Winslow and W. G. Clopton.

At the annual business meeting of the General Alumni Association of the University of Maryland, held on November 13, at 7 P. M., in the Hotel Rennert, just prior to the annual banquet, the following officers were elected for the ensuing year:

President, Dr. Charles E. Sadtler, class of 1873; vice-president, Mr. James W. Bowers of the Law Department; recording secretary, Mr. John Henry Skeen of the Law Department; corresponding secretary, Dr. Nathan Winslow, class of 1901; treasurer, Mr. Eugene Hodson of the Pharmacal Department; board of directors, Messrs. Dawkins and Revell, St. Johns; Drs. Adler (1895) and Earle (1870), Medical; Messrs. Rhodes and Mackenzie, Law; Drs. Gorgas and Geiser, Dental, and Messrs. J. B. Thomas and Hengst, Pharmacy.

Drs. Joseph E. Gichner, class of 1890; Robert L. Mitchell, class of 1905, and G. Lane Taneyhill, 1865, were elected to fill the vacancies of the Medical Department in the Alumni Council.

Dr. William V. Parramore, class of 1910, has been elected superintendent of the Georgia Tuberculosis Sanatorium at Alto, Ga.

Dr. John C. Hemmeter has sold his residence at 1735 Linden avenue to Dr. Charles E. Simon.

Dr. Maurice E. B. Owens, class of 1910, is located at Long Lake, Washington.

Dr. Walter S. Niblett, class of 1911, has been appointed assistant resident physician to the James Lawrence Kernan Hospital and Industrial Home for Crippled Children. Dr. William Henry Daniels, class of 1907, has been reappointed head of the dispensary at 2000 North Charles street.

Dr. William Joseph Durkin, class of 1911, is an assistant resident surgeon in Kings County Hospital, Brooklyn, N. Y.

Dr. Henry B. Athey, class of 1911, is located in Newark, N. J., where he is doing post-graduate hospital work.

Dr. Harry B. Gantt, class of 1880, of Millersville, Anne Arundel county, Md., is ill at the University Hospital suffering with septicemia. His son, Dr. H. B. Gantt, Jr., class of 1909, also of Millersville, is attending to his father's practice during his illness.

Dr. Joseph E Gichner, class of 1890, is conducting a German clinic at the University Hospital. He cordially extends an invitation to all interested to attend. As far as we know, this is the only clinic in Baltimore conducted in German, and it therefore affords an excellent opportunity to those desiring to familiarize themselves with German as employed in medicine.

Dr. Oliver Arnold Howard, class of 1906, of Marlinton, W. Va., was a recent visitor to the University Hospital.

Dr. John Guirley Missildine, class of 1911, of Wichita, Kans., was a recent visitor in Baltimore. We are glad to report that he was tied for third position in the Nebraska State Board medical examinations, and received the highest mark given in surgery.

Dr. Joseph McElhattan, class of 1906, is located at Freeport, Ohio, where he has succeeded in building up a lucrative practice.

Miss Mary Louise Gephardt, of University Hospital Training School for Nurses, class of 1911, is a patient at the University Hospital.

Dr. John R. Winslow, clinical professor of diseases of the nose and throat, was recently confined to his home with grip, but has sufficiently recovered to resume his duties. He will remove his offices from 114 West Franklin street to the Latrobe Apartments, Charles and Read streets, immediately upon their completion.

Dr. Randolph Winslow, class of 1883, and Dr. J. Mason Hundley, class of 1882, attended the meeting of the Southern Surgical and Gynecological Association, held in Washington December 12 to 14, before which meeting Dr. Winslow presented a paper.

The University of Maryland alumni are well represented in the list of the State's health officers. The following alumni are secretaries of the Board of Health in their respective counties:

Anne Arundel county, Dr. Walton Hopkins, class of 1904, Annapolis.

Baltimore county, Dr. James F. H. Gorsuch, class of 1876, Fork.

Caroline county, Dr. Frederick N. Nichols, class of 1902, Denton.

Carroll county, Dr. Charles Ryle Foutz, class of 1897, Westminster.

Charles county, Dr. Francis E. Jamison, class of 1907, Newport.

Dorchester county, Dr. Victor Calvert Carroll, class of 1906, Cambridge.

Garrett county, Dr. Henry Wheeler McComas, class of 1888, Oakland.

Harford county, Dr. Walter B. Kirk, class of 1893, Darlington.

Queen Anne's county, Dr. Arthur E. Landers, class of 1907, Crumpton.

Talbot county, Dr. Edward Richard Trippe, class of 1862, Easton.

Washington county, Dr. Jephtha Ellsworth Pitsnogle, class of 1889, Hagerstown.

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

In addition to the above secretaries of county boards of health, the University is represented by the following alumni as secretary of town boards of health:

Brooklyn, Anne Arundel county, Dr. Charles H. Brooke, class of 1891.

Cambridge, Dorchester county, Dr. Eldridge Eakin Wolff, class of 1899.

Brunswick, Frederick county, Dr. Levin West, class of 1886.

Aberdeen, Harford county, Dr. Charles Henry Kriete, class of 1895.

Kensington, Montgomery county, Dr. William Latane Lewis, class of 1892.

Laurel, Prince George's county, Dr. William Franklin Taylor, class of 1884.

Crisfield, Somerset county, Dr. Clarence E. Rogers, class of 1902.

Easton, Talbot county, Dr. Philip Lee Travers, class of 1902.

Dr. Herbert E. Zepp, class of 1904, is located at Rosedale street and North avenue, Baltimore.

BIRTHS

November 11, 1911, Franklin Clapp Tyson, son of Dr. William E. E. Tyson, class of 1905, of 2609 Jefferson avenue, East, Detroit, Mich.

ENGAGEMENTS

Mr. and Mrs. Roger W. Cull have announced the engagement of their daughter, Sarah White, to Dr. Richard Caldwell Hume, class of 1906, of Brookmeal, Virginia. The wedding will take place during this December.

Mr. and Mrs. L. Feitelberg, of 1635 N. Franklin street, Philadelphia, Pa., have announced the engagement of their daughter, Ida, to Dr. Henry Lyon Sinskey, class of 1908, of 1610 East Baltimore street, Baltimore, Md. The wedding will take place early in the winter.

MARRIAGES

Dr. Ernest Harrison Rowe, class of 1906, and Miss Nina Grace Horner, daughter of Mr. and Mrs. George Allen Horner, were married November 23, 1911, at the residence of the bride's parents, 201 Goodwood Gardens, Roland Park, by Rev. Dr. Robert M. Greene of Philadelphia, and Rev. W. L. McDowell of Baltimore.

The bride was attired in white satin, trimmed with old lace worn by both her mother and grandmother upon the occasion of their weddings. She wore a tulle veil caught up by orange blossoms and carried lilies of the valley and white orchids. Miss Marion Cameron was maid of honor. Dr. Herbert Schoenrich, class of 1907, was best man. The couple left upon a Northern trip and upon their return will reside at the Homewood Apartments, Baltimore, Md.

Dr. Harry Ralph Seelinger, class of 1910, of Norfolk, Va., was married on Tuesday, November 28, 1911, to Miss Mary Hamilton Mason, also of Norfolk.

Miss Grace Lawrence Dunderdale, University Hospital Training School for Nurses, daughter of Mr. and Mrs. Cleaveland Dunderdale of New York, was married to Mr. Walter Koppelman of Baltimore at Emanuel Protestant Episcopal Church on Wednesday, November 29, 1911, at noon. The ceremony was performed by Rev. Dr. Henry E. Cotton. The best man was Mr. Arthur Koppelman, brother of the groom, and the ushers were Messrs. William Koppelman, brother of the groom; Harry Baetjer, cousin of the groom, and Drs. William Royal Stokes, class of 1891, and George Dobbin, class of 1904.

The bride, who was unattended, wore a traveling suit of Copenhagen blue and a large picture hat ornamented with plumes, and carried a shower bouquet of orchids and violets. After the ceremony a wedding breakfast was served at the residence of the bride's sister, Mrs. George W. Dobbin, 56 W. Biddle street. Mr. and Mrs. Koppelman left for a Canadian tour, and upon their return will reside at Tudor Hall Apartments, Baltimore.

DEATHS

Dr. Pierre George Dausch, class of 1868, died suddenly at his home, Monument and Dallas street, Sunday, November 26, 1911, of heart disease, aged 65 years. Dr. Dausch was dining when stricken, and fell to the floor. He was placed in his bed and medical help summoned, but he only lived a few hours.

Dr. Dausch was a native of Baltimore, born April 30, 1850, the son of Anthony Dausch. He was educated at Loyola College, receiving the degree of A. B. and later A. M. from that institution. He was a member of the faculty of the College of Physicians and Surgeons in 1870, and at the same time editor of The Physician and Surgeon. He lived for a number of years at 121 Jackson Place, and was well known in East Baltimore. He is survived by his wife and three sons.

Dr. William F. Hengst, class of 1876, died at his home, 2131 N. Calvert street, Baltimore, on December 4, 1911, after a year's illness. Dr. Hengst was a son of the late Rev. Benjamin Hengst, a minister in the German Evangelical Church, and was a native of Baltimore. He is survived by his wife, Mrs. Martha Hengst. He was 58 years of age. Interment was in Loudon Park Cemetery, December 6, 1911.

Dr. Harry Victor Harbaugh, class of 1907, of East New Market, Md., died November 10, 1911, in the Cambridge Hospital, Cambridge, Md., of pneumonia, aged 28 years.

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SEE AMERICA FIRST.

By Randolph Winslow.

5. THE YELLOWSTONE NATIONAL PARK.

From Salt Lake City to the Yellowstone is a night's journey on the Oregon Short Line. This railroad lands its passengers at the western entrance to the Park, where they take stages for the tour of the Park, which can be accomplished in five days. The area of the reservation is 55 by 65 miles, and the greater portion of it lies in the northwest corner of the State of Wyoming, with narrow strips from the adjoining States of Idaho and Montana. The Park is in the heart of the Rocky Mountains, and is at an elevation of from 6000 feet in its valleys to 8300 at the Continental Divide, while many of its mountain peaks rise to an altitude of from 10,000 to 11,000 feet. There is probably no area of similar size in the whole world that presents so many and so varied objects of exceptional interest as are here grouped close together. Doubtless the whole reservation is replete with interest, but only a limited portion near its center is embraced in the official tours.

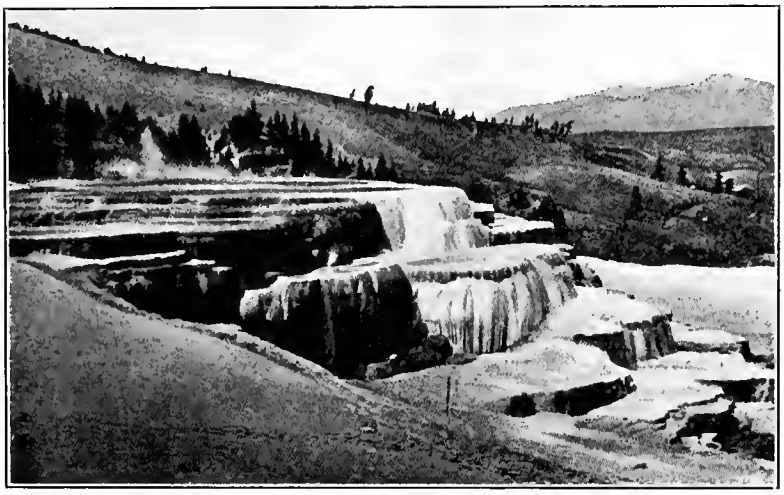
We reached Yellowstone Station at 7 o'clock on the morning of July 11, and, after breakfasting, secured a M.-Y. coach with seats for 11 passengers, in which we made the entire circuit. A few days previously a heavy snowstorm had occurred, but during our visit the weather was usually warm in the day time, but became cool at night. Mosquitoes were out in full force and attacked with great ferocity, but usually retired about 9 P. M. and allowed the discomfited traveler to rest in peace. The first stage of the trip was from the railroad to the Fountain Hotel, a distance of 19 miles. Starting at Christmas Tree Park, so called on account of the grove of straight pines through which the road runs, we follow the valley and canyon of the Madison River to the confluence of the Gibbon and Firehole rivers, and thence along the latter stream to the Lower Geyser Basin. This portion of the Park is attractive, but does not exhibit any features of great scenic beauty or of remarkable interest. One thing, however, is noticeable, not only here, but all over the Park, and that is the enormous destruction of timber that has occurred at some time, probably quite remote, as the fallen as well as standing dead trees are bleached to an almost sepulchral whiteness. At the Fountain Hotel one gets a substantial luncheon and then immediately inspects the geysers and hot springs of this lower geyser basin. At least he inspects some of them, for the basin covers an area of 35 to 40 square miles, and 693 hot springs and 17 geysers have been officially catalogued in this region. The springs contain hot or boiling water which flows continuously, while the geysers are springs that empty into heated caverns until a sufficient quantity of steam has been generated to cause an eruption of the water and steam, often occurring at stated intervals, but sometimes irregularly. The water is projected violently upwards, in some instances to a height of 250 feet, emitting not only steam and water, but in many cases a thundering noise that can be heard at a long distance. In Iceland and New Zealand geysers are found, but they are few in number, while in the Yellowstone Park 70 are found in a limited area, and more than 2000 hot springs. The boiling water holds salts in solution, and as it flows over the surface deposition of these chemicals takes place, forming mounds or encrustations which in many instances are very thin and through which the unwary are liable to break and to meet an untimely end. It is related that a woman, in a spirit of bravado, approached too close to the edge of a spring, broke through the

formation and disappeared from view forever. In dangerous places soldiers are posted to warn people not to approach too closely. The Fountain and Great Fountain geysers are the chief attractions at this point, but their intervals of eruption are so prolonged that the transient tourist stands but a slight chance of viewing them in action. Many hot springs are found here, from which steaming water constantly flows and which are often of great beauty. One of the most interesting of the natural phenomena to be observed here is the Mammoth Paint Pots. This is a depression, with raised edges, 40x60 feet in area, in which white and drab colored mud is in a constant state of ebullition. The mud is raised up to a limited distance, and there is a constant succession of plop-plop noises as bubbling up takes place in different parts of the mud caldron. Several miles distant is the Midway Geyser Basin, where there is another collection of springs and geysers. The Turquoise Spring, so called from its beautiful blue color, and the Prismatic Lake, which is a large bowl filled with water showing a great variety of hues; the Sapphire Pool, Black Pearl and many other pools are found here. Nine miles from the Lower Geyser Basin, on a somewhat more elevated plateau, is the Upper Geyser Basin. Time and words fail in which to describe this wonderful basin. Great geysers spout almost continuously within the field of vision, such as the Giant, which projects a column of boiling water 250 feet into the air; the Grand, Splendid, Beehive and Old Faithful. The latter is the most interesting, as it is situated close to the hotel, and every 65 to 70 minutes, day and night, gives its beautiful exhibition. The Morning Glory Spring is a silent pool of hot water which in shape and coloring resembles a beautiful blue morning glory. The Punch Bowl and Emerald springs are fascinating pools, while the Handkerchief Pool is a source of amusement to those who drop their handkerchiefs into it. The handkerchief disappears from view, but in a few minutes it is returned to you laundered. The writer found it both entertaining and useful, as his supply of handkerchiefs had gotten down to one, and that one very soiled. After a few ablutions in the spring it was returned to him washed and ready for use. A lady who thought she would try another spring, dropped her mouchoir in; it disappeared from view and she never saw it again. Old Faithful Inn is a beautiful, commodious and up-to-date hotel, built of logs, with the stairways constructed of split logs. Its central portion rises to the height of eight stories, though it is open to the roof. Our first day's journey of 29 miles terminated here, and after a good night's rest we were up betimes and ready for travel before 8 o'clock. Our route was mostly through forests and over the Continental Divide to Thumb Lunch Station, on the Yellowstone Lake, 19 miles distant. On the summit of the Continental Divide is a small lake, known as Two Ocean Pond, the waters of which flow from two outlets, one into the Atlantic through the Yellowstone, Missouri and Mississippi rivers, the other into the Pacific through the Snake River, an affluent of the Columbia. We get our first view of Yellowstone

OLD FAITHFUL INN, YELLOWSTONE PARK.

Lake as we approach Thumb Station. This lake is itself both beautiful and wonderful. It is about 15 by 25 miles in area and of great depth. It is the largest body of water at its altitude in the world, except Lake Titicaca in Peru. The water is mostly derived from the melting of the snow mantle of the surrounding mountain ranges, and is cold and pure. It is supposed that the seepage of water, through fissures at the bottom of the lake, into caverns in which the rocks are still heated from subterranean fires, is responsible for the great number of geysers found in the Park. There are a number of geysers, hot springs and paint pots found at Thumb Station, but none of great interest except the Fishing Cone. This is a mound with a boiling spring in its center, situated on the shore of the lake, upon which fishermen stand, and after catching the fish can turn around and boil it in the spring while still on the hook. At this point one can take an electric launch and travel comfortably to the other end of the lake for $2.50, or he can resume his journey by coach, and after an exceedingly dusty drive, during which we were almost devoured by mosquitoes, he reaches the Lake Hotel at the outlet of the lake, 16 miles distant. There is but little of interest to be seen on this drive and much discomfort to be experienced; hence one will do well to take the boat instead. The river at the outlet is teeming with fish, and parties enjoy excellent fishing here. The hotel is a large colonial-looking building where guests frequently make prolonged visits. One of the interesting sights here is the feeding of the bears on the refuse from the hotel. As night approaches large numbers of wild bears flock to the feeding grounds and gorge themselves with the garbage that is thrown out for their benefit. If unmolested, they are rarely dangerous, though they have been known to attack human beings, unprovoked. Likewise they do not usually molest other animals, but during our visit a bear killed a fawn after a fight with its mother. The view from the Lake Hotel is beautiful; the waters of the lake, either flashing in the sunshine or shimmering in the moonlight, are equally attractive, while the snow-capped mountains in the distance form a suitable setting for the scene.

The third day's journey is from the lake to the Grand Canyon, a distance of 19 miles. This is a pleasant drive through a parklike country called Hayden's Valley, in which herds of elk and other animals are usually seen, as well as flocks of geese, swans and ducks feeding in the river and pools in this portion of the Park. Mud geysers are also seen on this drive that are in a constant state of activity, and from which vapors of sulphuretted hydrogen are constantly escaping. As we approach the canyon the river becomes rapid and tumultuous, and then dashes over a perpendicular cliff 112 feet, constituting the Upper Falls. Continuing its riotous way, the rapids again make a sudden drop of 360 feet, forming the Lower or Great Falls of the Yellowstone. We are now face to face with one of the most beautiful scenes in the whole world—the Grand Canyon of the Yellowstone. This cleft is not so stupendous and sublime as the Grand Canyon of Arizona, but it



MAMMOTH HOT SPRINGS, YELLOWSTONE PARK.

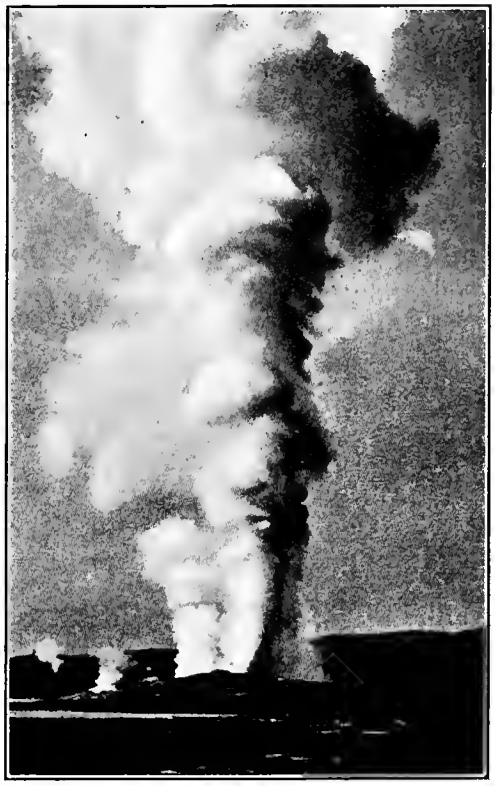
HOT SPRING CONE, YELLOWSTONE PARK.

is much more attractive. It is only about 10 miles in length, 1200 feet in depth and less than a mile in width, but for brilliancy in coloring it is a mighty picture painted by nature's master artist and unapproachable by man. The prevailing color is a bright yellow, whence the name of the river and Park, but intermingled with reds and pinks, green and orange, white and brown, gray and purple, while the rocks themselves are sculptured by torrent and storm into many fantastic forms. One might well linger long here and marvel at the wonderful handicraft of nature and of nature's God.

The new Canyon Hotel is an enormous structure of ornate design, with every modern convenience. Everything in the Park is under the control of the Government; hence the charges for hotels, camps, conveyances and outfits are uniform and imposition is almost impossible. There are permanent tent camps for those who prefer to live in a more rustic manner, and portable outfits for those who long for the still simpler life. Our fourth day's journey was a long one, from the canyon to Norris Geyser Basin and thence to the Mammoth Hot Springs. Norris Geyser Basin is situated along the upper reaches of the Gibbon River, which unites with the Firehole River to form the Madison, and all the most important geysers and hot springs drain into these streams. This region is also very remarkable, as here are found a large number of geysers that are in almost constant eruption, and are evidently due to shallow springs in caverns where the heated volcanic rocks are very close to the surface. In fact, one

CANYON FROM BRINK, YELLOWSTONE PARK.

must walk on boards over this thin crust under the direction of a guide, and one realizes somewhat the significance of the old adage, "walking on a volcano." The Constant Geyser erupts about every minute, the Minute Man every one and a half minutes, but they only project their columns 15 to 20 feet upwards. There is here also a very peculiar geyser that erupts cold water, but it is ejected by steam. The Black Growler emits a peculiar sound, as well as a vile odor. Numerous other geysers and pools of interest and beauty are found here, but we must resume our journey after a substantial lunch. The 20-mile drive to Mammoth Hot Springs and Fort Yellowstone is replete with interest. The twin lakes are two bodies of water connected with each other, one of a beautiful deep blue color, the other greenish in tint. The road passes also Beaver Lake, which is an artificial lake made by beavers damming a stream and with a colony of beavers still occupying a house on its bank. Obsidian Cliff is a mountain of volcanic glass, rising to a height of 250 feet and with its exposed face 1000 feet in length. The color of the obsidian is mostly black, with lighter streaks traversing it. As blasting is not permitted in the Park, a roadbed was made by building great fires around the blocks of glass and then dashing cold water upon them, thus shattering the brittle mass. In former days Indian tribes frequented this place to make arrowheads and other implements of this material. It is said it was neutral ground, used in common by all the Rocky Mountain tribes. Near this cliff one stops to drink from the appollinaris spring, which is a pleasant water, but not effervescing as far as I could judge. Numerous high mountain peaks are to be seen on this drive, the loftiest of which is Electric Peak, over 11,000 feet in altitude. Traversing Swan Lake Basin, a high mountain prairie, we come to Golden Gate Canyon and Viaduct. The roadway here is blasted from the rocks and is carried around the most difficult projection on a beautiful viaduct. This narrow pass is called the Golden Gate on account of the prevailing coloring of the rocks. The road now passes through a wild stretch of fantastically broken boulders, then through a gap in the silver-gray rocks known as the Silver Gate, and rapidly descending we reach the Hot Spring Terraces, and soon alight at the Mammoth Hotel. This place is but five miles from the northern entrance to the Park at Gardiner, and one might well leave the Park by this exit and take the Northern Pacific Railroad to St. Paul, but our itinerary called for a return to Salt Lake City and another long coach ride to the western portal at Yellowstone. There are no large geysers at Mammoth Hot Springs, but a series of remarkable terraces and pools, from which hot water is constantly running. The hot water holds carbonate of lime in solution, and as it escapes the lime is deposited, forming chalky mounds, beautifully terraced. Where the formation is old and dry it is pure white in color, but where the hot water runs an algous growth forms,



GIANT GEYSER, YELLOWSTONE PARK.

and the terraces are yellow, brownish red or greenish hued. These terraces are very extensive and cover acres of surface, and rise to a considerable height. The most prominent ones are Jupiter and Minerva terraces, but there are a number of others. The Devil's Kitchen is the crater of an extinct spring into which one can enter, but the atmosphere is hot, damp and evil smelling, and when you have descended into its depths you wish you had not done so. The Devil's Thumb and Liberty Cap are peculiar upright formations, the cones of extinct hot springs. Fort Yellow-

stone is the military headquarters of the Park, and several troops of cavalry are stationed here to police the Park and prevent disorder and poaching. The penalty for killing wild animals is very severe and is rigorously enforced. We saw a drove of 17 buffaloes grazing here, several of them having only recently been captured and placed with the tamer animals.

After a good night's rest we were up early and off by 8 o'clock on our last day's ride of 46 miles. We retraced our steps to Norris Geyser Basin, reviewing the scenes of the previous day, and thence to the railroad terminus. The route along the Gibbon River and through the Gibbon Canyon was interesting and pretty, but the road was dusty and the trip tiresome, and we were glad to reach our destination about 5.30 P. M., having driven 46 miles since leaving Hot Springs. After regaining possession of our belongings at the station and getting a substantial dinner, we entrained for Salt Lake City.

There is so much to be seen in the Yellowstone Park and so little time in which to see it that one gets a very superficial and confused idea of its wonders and beauties. Indeed, there are many beautiful mountains, valleys, lakes and waterfalls that the ordinary visitor does not see at all. Not far off the line of travel and readily accessible as a side trip is a standing forest of petrified trees, as well as others where the trees are thrown down and shattered. To obtain a reasonably accurate idea of the Park would require at least a month's sojourn in the summer time. In the winter it is covered with many feet of snow, and is not open to the public, though the Government officials and soldiers remain at Fort Yellowstone.

Dr. Milton Morris Whitehurst, class of 1899, has just opened the Liberty Bell Candy Store and Lunchroom on Lexington street, near Charles. The place is immaculate and most tastefully arranged. The team of oxen, drawing a cart on which is mounted a replica of the Liberty Bell, which is seen daily on the streets as the advertisement of the place, is exciting much interest, as its quaint and slow plodding is so distinct from the average sight which greets the Baltimorean's eye. Another huge bell is swung over the door, and one almost imagines they hear its sound on a windy day. We wish Dr. Whitehurst all success.

ACUTE FLEXURES OF SIGMOID AND COLON DIAGNOSED BY THE PROCTOSCOPE,

By J. Dawson Reeder, M.D.,
Baltimore, Md.

The term itself describes the condition—a sudden or sharp bend of the gut upon itself, narrowing or obliterating the caliber. The rôle in the production of disease, which is attributed by internists to the absorption of retained, fermenting or putrifying fecal matter, renders any study throwing light upon these cases both interesting and important. It has been my good fortune to have under observation several cases which were so diagnosed by use of the pneumatic proctoscope, and subsequent operation verified the condition without a single exception.

Flexures may be congenital or acquired. The congenital are all due to the turning of the rectum to the left at its upper end, and thus bringing the two fixed ends of the sigmoid in close apposition, so that the long loop in between is necessarily acutely flexed either when it rises into the abdominal cavity or drops into the pelvis. In reviewing the literature upon this subject I was surprised to find that the greatest number of cases reported by any one author were by Tuttle of New York, who gave in the *New York Medical Journal* of March, 1908, a series of 11 cases. It is also especially interesting to find that nearly every case gives identically the same history, especially if proctoscopic examinations are compared.

The cases under my observation, which I will report in detail below, have been entirely confined to the sigmoid, while those by Tuttle have included cecum and sigmoid, but their histories are very similar in every respect. Inflammation of the pelvic organs, oophoritis and salpingitis may extend to the sigmoid and cause adhesions and angulations of any degree, and are the most frequent causes except, perhaps, local or general peritonitis, when there is no disease of the sigmoid itself.

Adhesions of two or more appendices epiploicae, were found by Tuttle to have caused most distressing symptoms. Chronic appendicitis, if not a cause, is at least a comparatively frequent complication, producing flexures of the right side. One of the chief causes of constipation, and that to which more importance is attached than any

other mechanical obstruction, except, perhaps, stricture, is acute flexure at recto-sigmoidal angle.

In the normal condition the empty sigmoid lies in the pelvis, between the rectum and bladder or uterus, thus causing an acute flexure between these two organs. In cases of pelvic inflammation it not infrequently happens that it becomes adherent to the rectum or to the floor of the pelvis, thus becoming limited in its motions and prevented from rising into the abdominal cavity. This can easily be demonstrated with the pneumatic proctoscope. Where the pelvic colon is normally mobile inflation will cause it to rise into the abdominal cavity, especially if in the knee-chest position, and the straight tube can easily be introduced to the extent of 10 inches. When, however, on account of such adhesions, obstructions in the form of tumors, etc., this flexure cannot be straightened out, it is very difficult or practically impossible to pass the tube further than four or five inches. Tuttle reports one case in which the sigmoid was prevented from rising by the vermiform appendix passing down across its anterior surface and adhering to the peritoneum of the pelvis, just to one side of the bladder. Attempts were made during several months to pass the straight tube into the patient's rectum, and they always caused great pain until the appendix was removed. As soon as this was done the sigmoid was sutured to the abdominal wall (sigmoid-opexy), and when the patient had recovered from the operation it was possible to introduce the tube without any difficulty. Nearly every case that I have seen presented a large band of adhesions from one-half to three inches in breadth, extending from the left iliac fossa around a knuckle of sigmoid. These bands form a distinct mechanical obstruction, especially when the gut becomes distended with gas, and the entire obstructed area can be distinctly palpated on abdominal wall.

Symptoms.—There is always constipation or fecal stasis, distension and history of previous pelvic disturbances. In the congenital type, which the specialist rarely sees in early life, there is always history of colic, distended abdomen and constipation, accompanied with indigestion. As the child grows up it is called chlorotic, but is really toxic from absorption of producets of retained feces. If a girl, there is usually delayed or irregular menstruation, imperfect development and often intractable leucorrhea. The constipation, flatulence and colicky attacks persist. In the acquired angulations there is usually in addition to the constipation and distended sigmoid a history of dysentery, typhoid, colitis, sigmoiditis, pelvic peritonitis or inflammation of pelvic organs. The patients are constipated, muddy complexioned and have white tongues, flatulence and pass more or less mucus with their stools, the latter often being their most distressing symptom.

Examination may not show any hemorrhoidal or other abnormality of the rectum, and Houston's valves may be soft and pliable; but it always shows some point near recto-sigmoidal juncture where the tube is obstructed against gut wall, and even with atmospheric distension we dare not use further force in trying to pass the tube beyond this point. Often there are abrasions or ulcerations at the angulation. Another symptom of which many complain is incomplete evacuation; they go to stool four or five times daily to pass what amounts to an ordinary stool; they even have to go several times to relieve themselves of a high enema.

Among the causes reported by Tuttle are the following interesting ones:

1. Extensive adhesions of sigmoid to vertebral column.
2. Acute flexure of sigmoid, due to close apposition of its fixed point with long mesentery to intervening loop. The flexure at both its points is occasioned by accumulation of gas and lifting up of the long loop into the abdominal cavity.
3. Acute flexures of sigmoid from adhesions between appendices epiploicae.
4. Acute flexures of sigmoid on right side; chronic appendicitis.
5. Adhesions of sigmoid to tubes and ovaries.
6. Large band of adhesions binding sigmoid down into left iliac crest—Dr. Wyeth's case.

In the cases operated upon in the University Hospital I have been unable to pass the 10-inch sigmoidoscope farther than about four or five inches beyond the sphincter even with pneumatic dilatation, and several of these were under anesthesia with parts perfectly relaxed. In presenting these facts I do not wish to convey the idea that diagnosis of these conditions can only be made by the aid of the proctoscope, as the history of previous inflammation and palpation of a doughy mass in the region of the sigmoid will readily suggest the condition present, but failure to introduce a straight tube is absolute proof of existing obstruction.

The majority of cases seen and operated upon have been under the care of Prof. St. Clair Spruill, who was first to call attention to this condition about five years ago in the case of Dr. S., who gave all of the symptoms above noted, and proctoscopic examination at that time resulted in diagnosis of cancer. Dr. S. was opened at St. Joseph's Hospital and a large band of adhesions was found, completely encircling a large portion of gut and binding it down to left side of bladder, then reflecting over anterior abdominal wall. The adhesions were broken away, all raw surfaces covered over with peritoneum and abdomen closed. Patient rapidly improved and all symptoms completely disappeared.

Case No. 2.—A. F.; male; aged 24 years. March 30, 1910. Occupation, conductor. Attending surgeon, Prof. St. Clair Spruill; assistant, Dr. Hooper. Complaint, "pain in left side."

About five years ago patient was suddenly taken with pain in upper left side of abdomen, extending through the back and down left thigh. This continued for about three days, there being a constant ache all the time, with paroxysms of very sharp pain, which were so severe as to cause patient to double up. He stated that during this period he would void his urine about every 12 hours; just before micturition he would have severe paroxysms of pain. Patient was free for some time of these pains until last June, when he was taken exactly similar to above described, compelling him to lay up for a complete rest of several days. In July he went to a hospital and a cystoscopy was done. He stayed only a few days and left in same condition.

Entered University Hospital, and April 3, 1910, Dr. Ashbury made following report of X-ray No. 689: Negative for stone in left ureter and kidney; two masses located upon sigmoid and descending colon, which may be foreign body in colon or surrounding structure. X-ray No. 689, second: Extended shadow of psoas muscle; otherwise negative. The two masses above mentioned are not shown.

April 9, 1910: Patient taken to operating-room at 10.30 A. M.; prepared in usual manner. Incision made in left side, parallel to median line, through left rectus muscle about five inches long. Peritoneal cavity opened and contents of left lower quadrant examined thoroughly.

The sigmoid was found to be adherent both to the bladder and side of pelvis. These adhesions were broken up with considerable difficulty, the raw surfaces covered with peritoneum, the abdominal cavity thoroughly cleansed and the abdomen closed.—Dr. Hooper. Patient did very well; suffered for several days with retention and had to be catheterized.

May 6, 1910: After castor oil was freely effectual no bad after-results noted. Symptoms cleared up and appetite became good; bowels regular. No abdominal pains whatsoever. Discharged May 9, 1910, cured.

Case No. 3.—Milton D., aged 35 years. May 2, 1910.

Entered University Hospital complaining of pains in lower left quadrant of abdomen. Acute sharp pains would wear off in a few days, leaving a dull aching place, which would remain for a week or more. Attacks would become more frequent if patient allowed himself to become constipated. When his bowels were free his pain was markedly less, but always present. Also complained of pains in his hips and thighs; was unable to walk more than 200 or 300 yards without feeling that hips would give away; his entire body felt tired. This disappears at night after rest, and he did not complain of dragging his feet when he walked.

Lower extremities "go to sleep" very easily. Patient complains of dull aching pain across the back, which interferes with anything he attempts to do.

Abdomen.—Intercostal angle wide; abdominal walls of good tone; no muscle spasm. In left lower quadrant of abdomen, just above the crest of ilium, there is noted on deep palpation a definite mass, movable, tender and seemingly round. Nothing else abnormal noted in abdomen.—Dr. Hooper.

Diagnosis. — Reflex spinal irritation, due to dragging of mesentery of sigmoid and descending colon.—Dr. Spear.

May 5, 1911: Patient was prepared for operation at 10.30 A. M. by Dr. Spruill. His abdomen was opened on left side through the rectus muscle; contents of left side of abdomen examined. The sigmoid was found to be twisted upon itself and tied down to side of pelvis with adhesions. These were broken away and raw surfaces covered over with peritoneum. On close examination the sigmoid was found to be thickened on one side, as was the mesentery of this region; the mesentery was pulled down over the bowel and

held in place by being attached to the peritoneum; abdomen closed with silk sutures and skin with silver wire. Patient returned to bed in very good condition.

May 21, 1910: Patient discharged; condition cured. At time of discharge he was in excellent condition, presenting none of the symptoms.

Diagnosis.—Ulcer of sigmoid, with adhesions to side of pelvis.

Case No. 4.—Mrs. B.; aged 31 years; Walbrook, Md.; attending surgeon, Dr. Spruill.

May 18, 1910: One week prior to entrance patient was taken suddenly in the middle of the night with stabbing pain in the left side of the abdomen. The pain was so severe that, according to her statement, patient was thrown into convulsions. She then noticed a feeling of fullness in the lower left quadrant of the abdomen, as if a large mass were there; the above-mentioned pain radiated down her left limb and up her left shoulder, and she seemed very much distended with gas. The pain lasted for about an hour, when a physician was called in and administered morphia, which gave relief. The following day the patient felt very badly, the pain was still present, and she was generally uncomfortable. On that day she had one severe paroxysm of pain, and from then to the present time has had from one to three attacks every day. She was always more or less constipated, and preceding the initial attack her bowels had not moved for over 24 hours. Patient suffered from some headache during these attacks. She complains now of aching in lower part of her back. Two years ago the patient was operated upon; her tubes and ovaries were removed. A month or so after the operation the patient noticed that she was constipated, and had to take medicine of some character constantly for this trouble. She also began to suffer from acute indigestion.

No pulmonary complaints; no genito-urinary complaints; no cardio-vascular symptoms. Past history negative (except before-mentioned operation). Family history negative.

Intercostal angle wide; abdomen prominent, with very large amount of subcutaneous fat; pain on left side on deep pressure, and in lower left quadrant was found an ill-defined soft mass easily palpated.

No glandular enlargement; spleen and kidneys not palpable.

June 19, 1910: Patient was taken to the operating-room, placed on table and anesthetized with ether. Abdomen cleansed in the usual manner. An incision about seven inches long was made through the left rectus muscle, peritoneal cavity opened and its contents explored. The sigmoid was found tied up with adhesions to the side of pelvis and bladder. These adhesions were broken and the raw surfaces covered as well as possible with peritoneum. The peritoneal cavity was closed with fine silk, muscles and fascia with medium silk, and skin with subcutaneous silver wire. The patient was returned to bed in good condition.

July 8, 1910: Patient discharged; condition cured.

Case No. 5.—Miss H.; aged 21 years; city. Patient, a small girl of poor stature, who had been ill for some months. Previous to the examination she had been operated upon several times for peritonitis and post-operative adhesions. At the request of Dr. W. K. White, I proctoscoped the patient at her residence, but was unable to introduce my straight tube farther than about five inches. The patient had been confined to bed for some months, suffering from nausea, vomiting and extreme mucous colitis. A laparotomy was advised after tonic treatment and rest. The patient was taken to St. Joseph's Hospital and opened by Dr. Spruill.

A large ulcer was found in the stomach, for which he did a gastro-enterostomy, and upon exploring the pelvis he found a large knuckle of sigmoid, bound down in the left iliac fossa, completely surrounded by adhesions, which extended over to the bladder. These were broken and the abdomen closed in the usual manner. The patient at last report was improving rapidly, and promised to be a cure.

Case No. 6.—Mrs. C. C. H.; aged 45 years; Hyattsville, Md. Referred to me by Dr. T. E. Latimer, Hyattsville, Md. Attending surgeon, Dr. Reeder. November, 1910.

Patient was a very small ill-nourished woman, the mother of three children, whose ages ranged from 14 to 19 years. Since birth of last child she has suffered continuously of pain in abdomen, constipation and loss of weight, which has been gradually increasing in severity. Was called to Hyattsville by Dr. T. E. Latimer; found patient confined to bed, where she had spent best part of past three months, nervous and emaciated, her mental symptoms having become so pronounced

that the family had begun to give it serious consideration.

Patient presented a sallow, dried-out appearance, tongue white, thick and furrowed; eyes dull and listless, with marked nervous tremor of extremities; intercostal angle narrow and body ill-nourished.

In left lower quadrant of abdomen, above the crest of ilium, was noted a rigidity which, upon deep palpation, presented a doughy mass, freely movable, but painful. With the assistance of Dr. Latimer patient was placed in knee-chest position, and our attempt to pass 10-inch sigmoidscope resulted in failure, as it would not pass beyond the second portion of rectum even under atmospheric distension.

Patient here stated that the dragging-down sensations caused nausea and feelings of suffocation.

Her bowels only moved about every four to six days, and then only by use of a purgative. This condition had existed for the past four years.

Operation was advised after patient had received tonic treatment and purgation. January, 1911, patient was taken to Sibley Hospital, Washington, D. C., and prepared for operation. With the assistance of Dr. Latimer and the house staff of the hospital I opened abdomen by left rectus incision; peritoneal cavity was explored, and a large band of adhesions extending from recto-sigmoidal angle was found, extending over broad ligament, and fundus of uterus closely adhering the rectum to uterus and bladder. Adhesions were broken away and dissected out; raw surfaces covered over with peritoneum and held by fine silk. Region of appendix was then explored, and presented a thickened, bluish appearance, which caused us to remove appendix. Abdomen was closed in usual manner and patient returned to bed.

On morning of fourth day saw the patient for the first time after operation, and found temperature normal, but patient suffering great pain from gas and distension produced by laxative, which up to this time had not been effectual. Enema of 10 per cent. hydrogen peroxide was ordered, but before it had been administered bowels moved and patient was immediately made comfortable. Improvement from then was rapid and uneventful, and patient was discharged from hospital on tenth day. Her bowels moved daily without laxatives and her color was greatly improved. My last report from Dr. Latimer says she is attending to all her household duties, has gained rapidly in weight and her mental condition has completely cleared; bowels move regularly without aid of purgatives, a condition which has not existed for at least four years.

Diagnosis.—Adhesions of sigmoid.

Result.—Cured.

Conclusions.—In presenting the series I do not wish to convey the idea that proctoscopic examination is absolutely necessary, but do claim that it makes diagnosis absolutely positive. If you fail to pass the 10-inch sigmoidoscope without giving pain, you must at once eliminate possible stricture or malignity.

No physician in general practice is justified in prescribing for rectal disease upon the patient's diagnosis of internal or bleeding piles, as many an operable case of cancer has been so treated when, six months later, the unfortunate individual must be condemned to death. Many cases of so-called neurasthenia have a definite pathologic cause, the intestine being the most frequent seat.

Dr. Axtell's article from Billingham, Wash., stating that adhesions of sigmoid are a frequent cause of epilepsy should receive most careful and serious consideration from every physician and surgeon.

The partial list of cases as above reported are conclusive evidence of the value of proctoscopic examination, and my list of examinations made at the University Hospital and Bayview have had their diagnosis confirmed by the surgeons whom I have had the honor to serve, and it is quite evident that this process will in the very near future be a part of the routine examination of every patient admitted to hospitals for treatment where a general physical examination is required.

Professional Building,
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Dr. John Aldridge Gibson, class of 1901, of Leesburg, Va., writes: "I am enclosing a clipping telling of the death of poor Joe Milton. It has broken me all up, as a finer fellow never lived. I have just gotten over an attack of appendicitis, and back to work again, feeling the worse for wear, although I was in the hospital only nine days. I was shot into the hospital six hours after I was taken, and consequently had a perfectly clean case."

THE JACKSONIAN METHOD OF AMPUTATION OF THE BREAST FOR MAMMARY CANCER.

By Willis Linn,
Senior Medical Student.

When one is asked to prepare a paper on a subject that one knows little or nothing about, it becomes by the nature of things that the work will all be second-hand, and whether it comes from the textbook, from the journal or from the teachers matters little. Realizing that probably but one man out of every fifty that graduates in medicine practices major surgery to any extent whatever, and that no more than one out of every hundred will ever do any operation exactly as it is set down on paper, I shall endeavor to give only the operation in the words of its originator, J. W. Jackson, M.D., of Kansas City, Mo., leaving discussions and modifications for wiser heads than mine. According to Jackson (*The Journal of the American Medical Association* of January, 1910), the technique is as follows:

Before proceeding with the operation itself, he finds it a great advantage to first mark off with a single scratch the complete plan of skin incision. Being careful that the portion of the incision which surrounds the breast is always carried beyond the bounds of the breast itself, so that all premammary skin is removed with the tumor, the skin incision is begun at a point about one and one-half inches below the middle of the clavicle, between the clavicular origins of the deltoid and the pectoralis major. From this initial point the incision is carried outward and downward with a slight curvature, whose convexity is outward and overlapping the inner margins of the deltoid muscle to the outer edge of the lower border of the pectoral fold. The incision is now curved around the outer edge of the pectoralis dissection and reaches slightly under the edge of the pectoral fold. Along the under margin of this fold it is carried to the chest wall, where it meets with the outer circumference of the breast near its lower border. The remaining portion of the incision is made in the form of an ellipse about the breast, with its long axis somewhat from above, downward and outward, so the outer portion of its circumference partially parallels the descending first incision. In operating, this descending incision alone is made at the beginning of the operation. With the incision thus far carried, he has fashioned a quadrilateral flap with its base upward toward the clavicle and free below. This incision is carried through skin and superficial fascia down to the underlying muscles. This flap is then dissected upward from below, and above its base the skin is undermined well up to the clavicle. The flap is then wrapped up in hot salt towels to prevent any possible contamination in subsequent stages of the operation. With this flap lifted the pectoralis major muscle is exposed, with its fibers converging to its tendinous insertion in the humerus. The index finger of one hand is now shoved up underneath the pectoralis major and brought out again at its upper border, so that the entire pectoralis muscle is thus hooked up by the index finger and by blunt dissection separated out to its tendinous insertion. With the tendon of the pectoralis muscle thus lifted up, it is now divided by the scalpel very near its tendinous insertion with the humerus. The muscle retracts toward the chest and exposes the pectoralis minor invested in its fascia, which above runs to the clavicle and below spreads over the chest wall. The pectoralis minor is now isolated, as was the pectoralis major. It is also divided close to its attachment to the coracoid process of the scapula. As the pectoralis minor also retracts towards the chest, as did the pectoralis major, the wound is held apart by retractors or by the fingers of an assistant, and the axillary space is now widely exposed to view from the front.

As a rule, this exposure can be made without encountering any bleeding vessels which will require clamp or ligature. The axillary vein is now in view, and to its outer side and parallel to it an incision is made with the scissors of the fascia which surrounds the vessels. The fascia is now stripped off. The operator works steadily from without and above downward and inward toward the chest, and clearing fascia and glands. As he goes in this way the axillary artery and vein are isolated, and the branches supplying the axilla and going on to the chest are made plainly apparent. These vessels are at once double clamped and divided between clamps. He has usually found it necessary thus to ligate three or four sets of vessels. Time is saved by immediately ligating

these vessels and then removing the clamps. Thereafter there will be no trouble with hemorrhage from the axilla. Beginning thus at the apex and outer border of the axilla, the fascia and glands are completely cleaned by gauze, and scissors dissection working from the vessels inward toward the chest; this dissection should clear the subscapularis, serratus magnus and intercostal muscles of all connective tissue and fat cells as the dissection proceeds. The raw surfaces left are covered progressively with hot packs both to the proximal and distal wound surfaces, thus guarding against wound contamination. The dissection is now usually continued with gauze up under the pectoral muscles, under the breast and towards the chest. The point of attachment of the pectoral minor to the ribs is cut from underneath, flush with the ribs and the costal muscles from underneath. The operator now loosens up the pectoralis major to its fixed point of origin from the clavicle and sternum. While this is being done the breast is forcibly pulled back, so as to expose the deep cavity of the wound. The pectoralis muscle is now severed from beneath, close to its lines of bony attachment, and the perforating branches of the internal mammary are caught as soon as divided, as they come through the chest wall. After the pectoralis muscle has been entirely separated from beneath, the breast is allowed to drop back into its normal position. The skin incision is completed, dissected widely in every direction, and the breast and pectoral muscles underneath are removed. Branches of the mammary artery are now tied and forceps removed. Under these circumstances, the skin incision practically does not bleed at all, and it will be noticed that at no time during the operation were there more than a dozen clamps on the wound; in fact, if all vessels were tied when cut, it would be possible to do the operation with half this number, as the vessels when tied are tied at the base instead of tying innumerable branches, as is usually done. The removal of the infected tissue being now complete and the wound dry, the next step is the replacing of the flap and closure of the wound. The quadrilateral flap of skin and superficial fascia which formerly covered the axilla is now stretched out with tenaculum forceps and made to cover the defect of the chest wall created by the removal of the skin of the breast. This flap, which is one of three distinctive features of the operation, will always contract after it has been once loosened and will look as though it could be of little service. A couple of tenaculum forceps at the angles will spread it out, so it will cover a surprising amount of space. As the flap is now drawn over the chest he usually fixes it by attachments to the corresponding skin margins. Another distinct point now consists in catching up with a tenaculum the margins of the lower border of the pectoral fold, which represents the integument which originally formed the floor of the axilla. The skin is then stretched upward to the original skin beneath the clavicle. This brings the loose skin in the floor of the axilla up around the axillary vessels, and does away entirely with the axilla as a cavity in the subsequent anatomy of the individual. These tenacula likewise are usually clamped, and mark these fixed points of coaptation. Figure of eight tension sutures of silkworm gut are placed at these points to steady subsequent suturing. The remainder of the incision is closed with subcuticular sutures of silkworm gut. Drainage may be left by a stab puncture in the lowest recesses of the wound space, or may be done away with entirely. The wound is now covered by large square pads of gauze, wrung dry out of hot salt solution and finally strapped tightly. Separate pads cover the arms, so as to allow free mobility. When the operation is completed it will be observed that there is an appearance which is likened to that of a dipper with its handle running vertically along the inner border of the area. In conclusion, this method has the following advantages:

"First. The drawing of the skin over the axilla does away with a space which otherwise nature would have to fill in with scar tissue.

"Second. The flap forms a covering for the chest defect without any tension, and this does away with the necessity of grafting, which is so frequent in other methods.

"Third. The ligation of all vessels at their nearest point of origin, thus doing away with the ligating of so many vessels.

"Fourth, and lastly. The entire technical portion of the operation is completed before the chest is exposed by removal of the breast. Therefore, long exposure of an enormous area of raw surface, with the attending shocks, is done away with. As soon, in fact, as the breast is removed the wound is ready to be closed."

Students' Building, November 17, 1910.

THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, JANUARY 15, 1912.

"SPEED FORTH THE SIGNAL! CLANSMEN, SPEED!"

The Christmas holidays have come and gone, and the joys and happiness of the yuletide are but pleasant memories. We hope that much of the pleasure of the season has been derived from the bestowal of benefits upon others rather from the gifts that we have individually received. The practice of giving and receiving gifts at Christmas has become so universal that it imposes heavy burdens, at times, on those who are but ill prepared to bear them. Recognizing that December was a month in which our friends would have additional demands upon their means on account of the festivities of the season, we did not make much effort to push along our campaign for the pathological endowment fund, but nevertheless fared much better, both in subscriptions and in cash collections, than might have been expected. Now that the new year has opened to us, we hope we may succeed in a measure commensurate with the urgency and importance of the object we have in view. The writer possesses zeal and loyalty, but he lacks the necessary tact, influence and ability to carry the enterprise to a successful conclusion. He therefore not only solicits the aid of his colleagues and friends, but MUST have assistance. The work of raising this fund is difficult and not pleasant, but the necessity is great. We have lighted and raised aloft the flaming torch, and we now ask our loyal friends to speed the signal. "Speed forth the signal! Clansmen, speed!"

The subscriptions to January 1, 1912, are as follows:

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Dr. Herbert E. Zepp, 1904	25 00
Dr. Robert P. Bay, 1905	100 00
Dr. B. F. Tefft, 1905	100 00
Dr. Edward L. Bowlus, 1906	5 00
Dr. Jos. A. Devlin, 1906	10 00
Dr. W. F. Sowers, 1906	25 00
Dr. R. W. Crawford, 1906	25 00
Dr. Matthew L. Freilinger, 1906	10 00
Dr. Leo Karlinsky, 1906	20 00
Dr. J. F. Hawkins, 1906	25 00
Dr. Richard C. Hume, 1906	10 00
Dr. Frank S. Lynn, 1907	25 00
Dr. T. H. Legg, 1907	5 00
Dr. Albert H. Carroll, 1907	25 00
Dr. Edgar S. Perkins, 1907	25 00
Dr. W. Cuthbert Lyon, 1907	5 00
Dr. Thomas H. Phillips, 1908	25 00
Dr. J. N. Osborn, 1909	5 00
Dr. E. H. Kloman, 1910	25 00
Terra Mariae, 1911	3 50
Total	$9,275 50

Additions for the month, $245.

THE POE SCHOLARSHIP.

The subscription committee is endeavoring to raise $1500 for the purpose of founding a scholarship in the law department of the University of Maryland in honor of the late John Prentiss Poe, for more than 40 years a professor in that department. Mr. Poe was a public-spirited citizen and an ornament to the legal profession. Although not of our department or profession, the editor feels that many of our alumni were so well acquainted with Professor Poe that they would like to contribute to such a worthy cause. The fund will be administered by the trustees of the Endowment Fund of the University of Maryland, which ensures its perpetuity.

The appeal is as follows:

Dear Sir—The undersigned are establishing a John Prentiss Poe Scholarship at the Law School of the University of Maryland. We are all graduates of the 1911 law class. Our class was the last to learn from the lips, now sealed by death, of this great man.

Our plan is to raise $1500, which, at 5 per cent., would yield $75 per annum. The sum is to be handed over to the trustees of the Endowment Fund, who will pay the tuition fee of that Senior student who has obtained the highest rating in the first and second years' work. We decided to ask for only small contributions, so that all can share in this privilege and the interest in the Poe scholarship be widespread.

We feel sure that all members of the Maryland

Bar and alumni of the Law School of the old University of Maryland will, with pleasure, help in the establishment of this scholarship. Will you contribute $5? All money and checks are to be made payable in my name, Cyril Hansell.

Our dean (Judge Harlan) and Judge Stockbridge, among other prominent Maryland lawyers, have expressed their appreciation of our efforts and approval of our plan, and have contributed to this scholarship.

You can well understand that there is attached to our plan (involving, as it does, the approaching of so many people) a great deal of work, and the favor of a prompt reply would be greatly appreciated.

Courteously yours,

CYRIL HANSELL, Chairman;
EDGAR H. MCBRIDE,
LOUIS J. JIRA,
J. STEWART GLEN,
CHARLES H. BUCK,
GEORGE A. ROSSING,
CYPRIAN W. MCSHERRY,
Committee.

309 W. Lanvale street,
Baltimore, Md.

ITEMS

The Nurses' Alumnae Association of the University of Maryland held their annual meeting January 8, 1912, at the University Hospital. The following officers were elected for the ensuing year: President, Mrs. Page Edmunds (Millicent Geare), class of 1905; first vice-president, Miss Alice F. Bell, class of 1907; second vice-president, Miss Mary Gavin, class of 1908; secretary, Miss M. Gertrude Brady, class of 1911; treasurer, Mrs. Nathan Winslow (Margaret K. Massey), class of 1903; members of the executive committee, Miss M. E. Rolph, class of 1895; Mrs. Ethel Palmer Clark, class of 1906; Misses Clyde C. Dawson, class of 1908, and Susan A. Hostrawser, class of 1908.

Dr. Newton W. Herschner, class of 1906, of Mechanicsburg, Pa., and formerly assistant resident physician in St. Joseph's Hospital, Baltimore, was a recent visitor to the University Hospital. Dr. Herschner was so unfortunate as to break his arm while cranking his automobile some four weeks ago.

Dr. Albert G. Webster, class of 1911, of Davidsonville, Md., has rented the Presbyterian Manse at Churchville, Harford county, Md., and is practicing there. Churchville is the center of a wide area formerly covered by three physicians, of whom only one now is living; so doubtless Dr. Webster has selected a likely location.

Dr. Harry Dorsey Purdum, class of 1902, at present chief resident physician at Bayview Asylum, has been appointed assistant physician and pathologist to the Springfield State Hospital.

Amongst our Louisiana alumni are:

William A. Boylston, '71, Coushatta.

John E. Rooks, '05, Doyline.

Lafayette Lake, '06, Louisiana State Insane Hospital, Jackson.

William Buford Clark, '82, 1141 Baronne street, New Orleans.

First Lieutenant William Benjamin Borden, M.D., class of 1906, who has been a member of the Medical Reserve Corps for the past two years, on duty at Fort Bayard, N. M., has passed the preliminary examination for the Medical Corps of the Army. The examination was held at Fort Bayard, N. M., during the week beginning December 11. Dr. Borden was born in North Carolina in 1880. He has spent two years in a general hospital and one year in private practice before joining the medical department of the United States Army. He will be brought to the session of the Army Medical School, which begins October 1, 1912. Dr. Borden was under orders to sail for the Philippines on the January 5 transport, but on account of the short time he would remain in the Islands before it would be necessary for him to return to the States to come to the Army Medical School, this order has been revoked.

Majors William N. Bispham, class of 1897, and William F. Lewis, class of 1893, have been designated to take the course at the Field Service

School for Medical Officers at Fort Leavenworth, Kans., for 1912.

Lieutenant Benjamin H. Dorsey, Passed Assistant Surgeon, U. S. N., class of 1901, is a guest in Baltimore at the present time.

Dr. William Dodds Scott, Jr., class of 1904, of Cambridge, Md., and Dr. Frederick N. Nichols, class of 1902, of Denton were recent visitors in Baltimore.

Dr. Charles Percy Noble, class of 1884, of 1509 Locust street, Philadelphia, Pa., was born in Federalsburg, Md., November 15, 1863, son of William Davis and Mary Ann (Houston) Noble, and a descendant of American colonial ancestry. The first American Noble was John Noble, who settled in Somerset county in 1668, and received a grant of 500 acres of land from Charles Calvert, known as "William's Desire." Dr. Noble received his earlier education in the public schools of Federalsburg and Iowa Agricultural College. He then entered the University of Maryland, graduating in 1884. He immediately located in Philadelphia, serving for a time as first assistant and chief of clinic at Philadelphia Lying-In Charity Hospital, then surgeon-in-chief to Kensington Hospital for Women, then as gynecologist to Stetson Hospital, and clinical professor of gynecology to the Woman's Medical College.

Dr. Noble has written much for the medical press and several publications relating to diseases of women and abdominal surgery. He is coeditor with Dr. Howard A. Kelly of "A System of Gynecology and Abdominal Surgery." He has been president of the Philadelphia Obstetrical Society and the Northern Medical Society, and is a member of the British Gynecological Society, the American Medical Association, the American Gynecological Society, the Southern Surgical and Gynecological Society, and is a fellow of the College of Physicians of Philadelphia, besides holding membership in numerous social clubs. He is an Episcopalian, a member of St. Mark's Protestant Episcopal Church.

Dr. Noble married September 15, 1885, Miss Mira Rose of Newark, N. J. They have three children living—Charles Percy, Jr., Robert Houston and Dorothy—and one—Eunice—deceased.

The committee in charge of the work of founding the Poe scholarship is meeting with such generous and ready responses that they may be able to create two scholarships instead of one. Subscriptions have been received to date from Judge Henry Stockbridge of the Court of Appeals, Judges Henry D. Harlan and Walter I. Dawkins of the Baltimore Supreme Bench, Dr. Thomas Fell, president of St. John's College, and Messrs. Joseph C. France, William L. Marbury, Eli Frank, Albert C. Ritchie, D. K. Este Fisher, Samuel Want, Edgar H. McBride of Harvard, George Weems Williams, Bruner R. Anderson, Enoch Harlan, John Hinkley, Charles O. Laney of Dallas (Tex.), Leon E. Greenbaum, George A. Solter, I. Augustine Mason of Hagerstown, Harry Welles Rusk, John D. Nock and Cyprian W. McSherry of Silver City, N. M.

The committee in charge of the scholarship fund is composed of Cyril Hansel (chairman), Edgar H. McBride, Louis J. Jira, J. Stewart Glen, Charles H. Buck, George A. Rossing and Cyprian W. McSherry.

Amongst our Mississippi alumni are:
James A. Shackleford, '76, Greenville.
Edward C. Coleman, '85, Kosciusko.
Eugene C. Denson, '98, Meridian.

Miss Elizabeth C. Patterson, University Hospital Training School for Nurses, class of 1911, is assistant superintendent at the University Hospital.

Dr. John Rawson Pennington, class of 1887, of Chicago, Ill., is probably one of the best known of the University alumni. He was born in Corydon, Ind., September 3, 1858, the son of Charles Peter and Rebecca (Conrad) Pennington. He gained his education in the public schools of Corydon, Corydon High School, the Indiana State Normal School and the National Normal School at Lebanon, Ohio. He entered the University of Maryland in 1884, graduating in 1887. He served as an interne in the University Hospital during his last year there, and then became assistant to Dr. F. T. Miles in nervous diseases at the University. In 1889 he located in Louisville, Ky., and became assistant to the chair of gynecology and obstetrics in the Kentucky school

of Medicine, and was rewarded in 1891 by the conferring by that school of the degree of M.D. upon him. He served there for two years as assistant to Dr. J. M. Matthews in rectal diseases, then resigned and went to St. Mark's Hospital in London, England, to study fistula and other diseases of the rectum, taking a special course in rectal surgery. In October, 1893, he returned to America, locating in Chicago, where he has attained an enviable position. He was for a time professor of rectal diseases in the Chicago Clinical School, and resigned in 1900 to accept the chair of rectal surgery in the Chicago Polyclinical College.

Dr. Pennington is a fellow of the American Proctologic Society, a member of the American Medical Association, Mississippi Valley Medical Society, Illinois State Medical Society, Chicago Medical Society and the Physicians' Club of Chicago. He is a frequent contributor to medical literature and is standard authority on the subjects he treats. His contributions to International Clinics have attracted much attention.

Miss Jennie R. Garner, University Hospital Training School for Nurses, class of 1911, has been appointed superintendent of the maternity hospital of the University Hospital.

Announcement was made at the White House on January 5 that President Taft had selected Dr. Rupert Lee Blue, class of 1892, to be Surgeon-General of the Public Health and Marine Hospital, succeeding the late Walter Wyman. Dr. Blue was recently stationed at Honolulu and has been in the service since March 3, 1893.

It is rumored that Dr. Robert Albert Warner, class of 1895, of 119 North Carey street, will be appointed superintendent of Sydenham Hospital, succeeding Dr. Warren P. Morrill. Dr. Warner is a native of Baltimore, having been born here November 1, 1871, the son of Luther F. and Josephine (Etchison) Warner. He gained his early education in the public schools of Baltimore, and then matriculated at the University of Maryland, graduating in 1895. In 1904 he took a post-graduate course at the College of Physicians and Surgeons. He has served as clinical assistant at Bayview Hospital and as chief of clinic to Dr. John C. Hemmeter at the University Hospital. He married in 1900 Miss Carrie Brooks of Covington, Ky.

At the annual meeting of the Adjunct Faculty of the University of Maryland Dr. William Tarun, class of 1900, was elected president; Dr. E. H. Kloman, class of 1910, vice-president, and Dr. H. D. McCarty, class of 1905, secretary-treasurer, to serve for the ensuing year.

Dr. Walter S. Niblett, class of 1911, has been appointed assistant resident physician to the James Lawrence Kernan Hospital and Industrial School for Crippled Children.

Dr. William Henry Daniels, class of 1908, has been reappointed head of the dispensary of the James Lawrence Kernan Hospital and Industrial School for Crippled Children at 2000 North Charles street.

Dr. John Eugene McLaughlin, class of 1886, of Statesville, N. C., was born near Statesville, October 4, 1862, the son of Gen. Richard A. McLaughlin and Mary J. (Murdock) McLaughlin, and is a descendant of Scotch-Irish ancestors. He was educated in the public schools, Statesville Male Academy and the University of Maryland. In 1900 he took a full course in the New York Post-Graduate Medical School. He began practice in Cool Spring, N. C., in 1886, remaining there until 1900, when he removed to Statesville, where he has since resided. He diagnosed and successfully treated the first case of uncinariasis discovered in that part of the State. Dr. McLaughlin has been a member of the Iredell County Board of Health and professor of materia medica at the Statesville Training School for Nurses, of which he is vice-president. He is a member of the Iredell County Medical Society, the Iredell-Alexander Medical Society and the North Carolina State Medical Society.

Dr. McLaughlin was married September 17, 1890, to Miss Julia E. Murdock, and has two children—Edith M. and Esther B. McLaughlin.

ENGAGEMENTS

The engagement is announced of Miss Louise Irene Craig, University Training School for

Nurses, class of 1903, to Mr. James Upshur Dennis of Baltimore. The marriage will take place in Emanuel Chapel, Baltimore, Saturday, January 20, 1911.

BIRTHS

Dr. Walter W. White, class of 1896, and Mrs. White (Leonore Doyle), University Hospital Training School for Nurses, class of 1906, have announced the birth of a daughter, December 11, 1911.

Dr. Arthur Louis Felsenfeld, class of 1909, and Mrs. Felsenfeld, Garrison and Fairview avenues, Forest Park, announce the birth of a son in December.

MARRIAGES

Miss Emelia Augusta Strohm, University Hospital Training School for Nurses, class of 1910, was married in September, 1911, to Mr. W. G. Spalding of Brooklyn, N. Y.

Miss Martha Venable Edmunds, University Hospital Training School for Nurses, class of 1910, was married in October, 1911, to Dr. Dwight Gray Rivers, class of 1910. They are living at Fort White, Florida.

Mrs. E. B. Walls has announced the marriage of her daughter, Miss Clara Elizabeth Walls, to Dr. Norman Spear Dudley, class of 1901, on Thursday, December 21, 1911, at Wilmington, Del. They are residing at Church Hill, Md.

Dr. John Henry Von Dreele, class of 1911, was married on Wednesday, December 27, 1911, to Miss Marvel E. Scarff, daughter of Mr. and Mrs. William E. Scarff of Sharon, Md. The ceremony was performed at the parsonage of Grace M. E. Church, Baltimore, by the pastor, Rev. Mr. Beale. Miss Scarff is a graduate of the University Hospital Training School for Nurses, class of 1911. Dr. Von Dreele is also a graduate of the School of Pharmacy of the University, class of 1904. He served for one year as resident physician at the Municipal Hospital, Baltimore. The couple will reside at 846 West 36th street, Baltimore.

DEATHS

Dr. Enoch George, class of 1872, died at his home in Denton, Caroline county, Maryland, January 12, 1912, of pneumonia.

Dr. George was born in Sudlersville, Queen Anne's county, Maryland, June 30, 1850, the son of Dr. Enoch George, who died in 1858, and Catherine Boone George, and the grandson of Enoch George, a distinguished divine of the Protestant Episcopal Church and the fifth bishop of that church in America. Dr. George was educated in the public schools of Denton, Fort Edward Collegiate Institute at Fort Edward, New York, and later at a business college in Philadelphia, Pa. In October, 1870, he entered the medical department of the University of Maryland, graduating in 1872. He was an interne at the University Hospital during his senior year, and after graduation began practice at once in Denton, Md., where he remained until his death. He was for many years president of the Caroline County Medical Society. He was a member for several years and at one time president of the Caroline County Board of Education, and has served as county health officer, member and secretary of the Board of Health of the county, and also president and member of the Board of Town Commissioners of the town of Denton. He was elected a member of the Medical and Chirurgical Faculty of Maryland in 1891. Dr. George was well known in Caroline politics as a Democrat.

Dr. George married Miss Eva M. Horsey of Maryland, who survives him. He leaves two sons—Enoch George, Jr., and Dawson Orme George, a student in the Medical School of the University of Maryland, class of 1912.

Dr. William Constantine Pease Boone, class of 1872, of Plainfield, N. J., died on December 30, 1911, aged 67 years. Dr. Boone was born in Washington, D. C., April 16, 1844, the son of John Francis and Louise Anna Maria (Baker) Boone. His parents were both of old Maryland stock. He received his primary education at Washington Seminary (now Gonzaga College), Washington, D. C. He entered Georgetown University, but left his studies while in the junior year to enlist as a private in the Confederate Army, Company E, First Regiment Maryland Cavalry, and served throughout the entire war

between the States. After peace was restored he studied medicine under the private tutelage of Prof. Richard McSherry, then entered the University of Maryland, graduating in 1872.

He located in Plainfield, where he remained until his death. He was attending physician on the medical staff of Muhlenberg Hospital, Plainfield, for many years, and at the time of his death a director of the institution. He was also physician to several fraternal orders.

Dr. Boone married on April 11, 1872, Miss Annie Maria Hering of New York, who survives him. He also leaves a brother, Rev. Edward D. Boone of Loyola College, Baltimore, and three sons, Rev. Charles E. Boone of St. Mary's Seminary, Messrs. William Arthur and John Francis Boone, and two daughters, Misses Anne and Caroline Edith Boone.

Few things have more profoundly shocked the community of Rockingham county, Virginia, than the death of Dr. Joseph V. Milton, class of 1901, in Harrisonburg, Va., on December 16, 1911, of pneumonia. Dr. Joseph Vandevanter Milton was a son of the late Theodore Davisson Milton and Mrs. Lydia C. Milton, and was born near Lacey Spring, Va., 35 years ago. He studied at the Danville Military College and later matriculated at the University of Maryland. He spent some time in a hospital after his graduation, and then located in Lacey Spring, going into a partnership with Dr. Thomas F. Keen, class of 1880. In 1907 he was married to Miss Anne Page Maury of New York, who survives him. He also leaves his mother, five sisters and one brother. He was buried in Lakeview Cemetery, from St. Paul's Protestant Episcopal Church, with an escort of Masons from Hamilton Lodge, of which he was a past master. The active pallbearers were three of his brother-physicians—Drs. Thos. F. Keene, class of 1880; John Aldridge Gibson, class of 1901, of Leesburg, Va., and Albert Braden—and Messrs. A. C. Vandevanter, F. N. Kerr and G. Ernest Leith.

Dr. Milton was loved by all who knew him, and the most touching tributes have been paid to his memory by those among whom he labored. Many of his friends believe he incurred the attack of pneumonia from which he died in attending to his professional duties, and as one of the local papers expresses it, "it is generally conceded he simply sacrificed his young life to the exacting demands of his profession in what he nobly conceived to be his line of duty."

Dr. Summerfield Berry Bond, class of 1883, died at his home in Baltimore December 21, 1911, aged 50 years, after a lingering illness.

Dr. Bond was born in Baltimore April 9, 1861, the son of Hugh Lennox and Annie G. Penniman Bond, and comes of American-English ancestry. His literary education was gained in private academies and Phillips Exeter Academy in New Hampshire, and later in study in Europe. He graduated from the Medical School of the University in 1883, and took post-graduate courses in the Johns Hopkins University and Paris. He was chief of clinic to the professor of surgery in the University of Maryland from 1884 to 1886, and for a number of years clinical professor of genito-urinary diseases; then was for some years medical examiner to the Pennsylvania Railroad, and was located in Pennsylvania. During his stay in that State he married Miss Julia Valentine. For the past 10 years he was surgeon to the Baltimore & Ohio Railroad, and chief medical examiner of their relief department.

He is survived by his widow and two children, Misses Lydia Valentine and Julia Valentine Bond. The funeral was held from Emanuel Protestant Episcopal Church, Baltimore, on Sunday, December 24, 1911.

"A true friend of young men" was the title which Dr. Bond bore in medical circles in this city. This was due to his willingness to help students at the University and young physicians whose capital did not enable them to withstand the "lean" years of early-practice.

He was essentially a worker in his chosen field, although he was much attached to his home. He was little identified with the social life of the city, preferring to read in the company of his family and to chat occasionally with intimate friends at the University Club, of which he had been a member for a long time.

Fishing and sailing were his principal diversions, but, particularly after he become connected with the railroad company, he took only short vacations and contented himself with cruises down the bay.

Dr. St. Clair Spruill said of him:

"It is safe to say that Dr. Bond had more friends in the medical profession in Baltimore than any other man in that fraternity. He was

lovable, principally because of his sympathy for the downtrodden. His benefactions were accomplished with little fuss, but there are many here to testify to them."

BOOK REVIEWS

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially-Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners. By Leading Members of the Medical Profession Throughout the World. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A. Volume IV. Twenty-first series. 1911. Philadelphia and London: J. B. Lippincott Company. Cloth, $2 net.

Some of the articles of this volume and their authors are: "Enuresis: With Special Reference to Its Causation and Treatment," James Burnett, M.A., M.D., M.R.C.P. (Edin.), registrar Royal Hospital for Sick Children, examiner in materia medica to the University of Aberdeen, etc.; "Prophylactic Treatment of Hypertrophy of the Prostate Gland, with Remarks on an Efficient Method of Treating Acute Gonorrhea," Edgar G. Ballenger, M.D., and Omar F. Elder, M.D., Atlanta, Ga.; "Agar-Agar in the Treatment of Constipation and Diarrhœa," Dudley Roberts, M.D., attending gastro-enterologist, Brooklyn Hospital, etc.; "The Modern Treatment of Syphilis," Wm. R. Trimble, M.D., lecturer on diseases of the skin, New York University (University and Bellevue), etc.; "Senile Mentality," I. L. Nascher, M.D., special lecturer in geriatrics, Fordham University, School of Medicine; "Modern Instruments of Precision in the Study of Cardiovascular Disease," George William Norris, A.B., M.D., assistant professor of medicine in the University of Pennsylvania, etc.; "Rat-Bite Disease, with Report of a New Case," Frederick Proescher, M.D., Pittsburgh, Pa.; "The Operation for the Radical Cure of Inguinal Hernia with Local Anesthesia," J. A. MacMillan, M.D., Detroit, Mich.; "The Rational Treatment of Catarrhal Deafness and Tinnitus," Harold Hays, A.M., M.D., assistant surgeon in otology, New York Eye and Ear Infirmary, etc.; "Legal Facts a Physician Should Know in Surgical Cases," George K. Frink, M.D., San Francisco, Cal.; "The Successful Practice of Medicine," Thomas F. Reilly, professor of applied therapeutics, Medical Department, Fordham University, New York city.

It gives us pleasure to call attention to the article on "Prophylaxis of Prostatic Hypertrophy," by Edgar G. Ballenger, class of 1901. Dr. Ballenger, since graduating, has specialized in genito-urinary diseases, in which specialty he has attained marked distinction and success. As noted above, the contributions cover practically every aspect of medical endeavor. The volume will be found a veritable encyclopedia by general practitioners who desire to keep abreast of medical advances.

LABORATORY REPORT OF THE UNIVERSITY HOSPITAL.

Months of October and November.

Blood Examinations.

	Oct.	Nov.
Leucocytes Counts	220	228
Erythrocytes Counts	60	72
Differential Leucocyte Counts	22	28
Hemoglobin Determinations	88	92
Coag. Times	2	3
Smears for Malarial Parasites	30	36
Blood Cultures	8	10
Widal Tests	62	60
Wasserman Tests	31	40

Urine Examinations.

Routine Urinalysis (chemical and microscopic)	342	380
Total Estimations for Urea	17	25
Total Estimations for Urea in Blood.	12	18

Miscellaneous.

Gastric Contents (chemical and microscopic)	14	18
Feces (microscopic, etc.)	11	19
Sputum Examinations	20	24
Bacterial Cultures and Smears	26	32
Vaccines	5	7
Spinal Fluid Examinations	3	5
Sections of Tissue for Microscopic Examination	18	20
Autopsies	2	3

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SEE AMERICA FIRST.

By Randolph Winslow.

6. SALT LAKE CITY. ROYAL GORGE. COLORADO SPRINGS. PIKE'S PEAK. GARDEN OF THE GODS. BACK TO THE EFFETE EAST.

Salt Lake City is not situated on the Great Salt Lake, but is about 16 miles from that inland sea. It has made great improvements since my visit in 1905. Its streets have been paved with smooth pavements, and many fine new edifices have been erected; nevertheless, the air of mystery still envelops it, and one feels very much as if he was in a foreign land. It is the capital of Mormondom and derives its chief interest and importance from that fact. Brigham Young was a long-headed and wise man when he selected this pleasant valley as the site of his city of Zion, with its perennial stream of cool mountain water, which he called the River Jordan. Protected on the east by the Wasatch Mountains, and with a body of salt water 2500 square miles in area on the west, the extremes of heat and cold are almost never experienced, while one can enjoy the pleasures of salt-water bathing, on the one hand, or the invigorating mountain air, on the other, by traveling only a few miles in either direction. The Mormons were fond of likening themselves to the Israelites in patriarchal days, and in many respects adopted the same customs. Thus polygamy became one of their most cherished tenets, which has only lately been publicly discontinued, though many of the saints still have several wives. Joseph F. Smith, the President of the Church at this time, has five wives and numerous children. Brigham must have been a fine judge of women as well as of land, as he is reputed to have had 19 wives, some of whom had separate houses, while others lived in communal establishments. We asked a sour-visaged woman of uncertain age, who was employed at the Bureau of Information,

GENUINE AMERICANS, 1911.

how many wives President Young had. She replied in acidulous tones that she had never inquired; it was the man's business as to how many wives he should possess, and did not concern anyone else. In the center of the city is the Temple enclosure, 10 acres in extent, in which are the Temple, to which only the very elect are admitted; the Tabernacle, which is open to the public, and the Assembly Hall. The Temple is a tall, somewhat Gothic-looking structure of light granite, which was 40 years in building, and in which the most sacred and secret rites of the church are performed. The Tabernacle is an enormous and wonderful structure, capable of seating 10,000 persons. It is elliptical in shape, and may be likened to a prodigious eggshell cut lengthwise and placed on pillars. It is 250 feet in length, 150 feet wide and 70 feet in height from the floor to the ceiling. It has no central supports, but makes a sheer arch from side to side. The sides of the building between the pillars are doors that can be thrown open at a moment's notice and the edifice completely emptied almost at once. The acoustic properties of this building are probably unequaled in the whole world, as the dropping of a pin or the rustling of a paper can be distinctly heard the whole length of the auditorium. The organ is also one of the marvels of music, and can be made to imitate the human voice almost perfectly. We attended service here on Sunday. A prayer was offered by an official that might equally as well have been made by a Methodist or Quaker preacher. It differed in no manner from the invocations that one is likely to hear in any of the Christian churches. The music and singing of the immense choir was magnificent and inspiring, but the address that followed was a tedious recital of the great virtues of the Latter-Day Saints, which was intended to impress the Gentiles present rather than to edify the elect.

Saltair Pavilion is situated on the Great Salt Lake, and is a miniature Coney Island. Here one can enjoy the salt-water bathing, which, however, differs very much from that at any seaside resort, as the water is 22 per cent. salt and one cannot sink in it. While one cannot sink in the Salt Lake, he can very easily be drowned, as it is very difficult to right onself if by chance he gets his face turned downwards in the water. After bathing, like Lot's wife, he or she is converted into a pillar of salt, and requires a bath in fresh water to resume his normal appearance. The manufacture of salt from the water of the lake is a large industry, and is accomplished by piping the water to ponds, where it is allowed to evaporate, after which it is purified and is ready for use. While passing along a street we noticed the sign Chesapeake Restaurant, and on entering found the walls lined with pictures representing aquatic life and sports on the Chesapeake Bay. Incidentally we found the meals excellent and the prices reasonable.

TEMPLE AND TABERNACLE, SALT LAKE CITY, UTAH

Leaving Salt Lake City by the Denver & Rio Grande Railroad in the afternoon, we pass through a number of towns of no especial attractiveness, at which men and women, also not attractive in appearance, were to be seen, and thence traverse Eastern Utah in the night, our

destination being Colorado Springs. Early in the morning we are in Colorado, and our route is through the Canyon of the Grand River, which is a narrow defile through precipitous mountain walls 2500 feet in height. These rocks are of many colors, the reds being especially vivid and striking. Past Glenwoods Springs, through the Canyon of the Eagle River, which not only presents the peculiar coloring and characteristics just described, but the curious sight of mines being worked up and down the face of the perpendicular cliffs, we ascend the mountains and cross the continental divide at an elevation of 10,200 feet. Leadville is seen perched on the mountain top, and is said to be the highest modern city in the world. We are now on the eastern slope of

HANGING BRIDGE IN THE ROYAL GORGE, COLORADO.

the Rockies, and all the streams flow into the Atlantic Ocean. We follow the Arkansas River, which rushes madly downwards through narrow rock-ribbed walls, until at the Royal Gorge the cleft in the mountains is but 30 feet wide, and the train crosses on a hanging bridge that springs from the rocks on each side. The stars can be seen at noonday, and the sky is only a thread of blue seen through the gap a half mile up in the air.

Pueblo, a very busy town and the second in population in the State, is passed, and not long thereafter Colorado Springs is reached. This is a famous health resort, and is beautifully situated in the valley, with Pike's Peak raising his lofty head in the near distance. The Antler's Hotel is a splendid establishment and is a favorite resort. For a month we had been traveling and sojourning in rainless regions, but at Colorado Springs a sudden and torrential downpour overtook us, much to the delight of an old lady from the East, who piously gave thanks that she was permitted to see the rain descend again. Manitou is five miles from Colorado Springs, and is itself a resort of note, with its springs of soda and iron, its Cave of Winds, Garden of the Gods and many other attractions. From here the cogwheel railroad runs to the summit of Pike's Peak, nine miles distant. Pike's Peak is a wonderful natural monument, 14,147 feet in altitude, and standing out boldly, so that it may be seen for a great distance. It may be ascended on foot by those who like that form of travel; on mules, which is preferable, and by the railroad, which is the easiest, quickest and most comfortable way for a tenderfoot like the writer. The ascent takes about an hour and a half, and the route is beautiful and picturesque. Plunging almost at once into a narrow defile, the train ascends rapidly up a very steep grade, at times as much as 25 per cent. The mountain sides are heavily wooded, and riotous streams rush rapidly down. Here and there are rustic hotels, cottages or camps, where people were enjoying the open and free life of the highlands. Wide vistas open at times and permit views of snow-capped mountains and valleys clothed with beautiful verdure and sparkling with variegated flowers. At about 11,000 feet elevation the timber line is reached, and above this there are no trees, but extensive plateaus, on which only grass and hardy flowers grow. Still ascending, the engine groans, as if in mortal ag-

ony, as it labors, like Sisyphus, to push its load up the everlasting hill. The air becomes not only chilly, but rarified, and some people are oppressed and even overcome by the altitude. The writer only experienced some increased frequency in respiration and in the pulse rate, but no actual distress. Above 12,000 feet all vegetation ceases, and the top of the mountain is a mass of broken rock. The summit is a rounded, domelike apex, absolutely bare except when covered with snow, upon which is a small hotel and observatory for the accommodation of those who wish to spend the night in order to see the sunrise. From the summit probably the most magnificent view in the whole world is to be enjoyed if the day is clear. One is forcibly reminded of the incident recorded in Matthew, chapter iv, verse 8, where "the devil taketh Him up into an exceeding high mountain, and showeth Him all the kingdoms of the world and the glory of them." From this lofty eyrie the view is bounded only by the limitations of human vision. Almost the whole State of Colorado is spread, as a map, before the spectator, and Colorado Springs and other cities are seen as huge checkerboards in the distance. On the summit itself is the lonely grave of a young girl, with the inscription, "Eaten by mountain rats." What either the girl or the rats were doing up there is not mentioned. Certainly, there was nothing else there that the rats could eat. At the time of our visit the summit was free from snow, and the temperature was not disagreeably cold, though light overcoats were very comfortable. As has been stated, the timber line is reached at about 11,000 feet, and above this many colored flowers grow in profusion. At this elevation a pretty young girl boards the train and offers posies of Pike's Peak forget-me-nots for sale, which were both beautiful and fragrant. The drinking water of Colorado Springs is derived from this mountain, and there are successive reservoirs for collecting and distributing the water almost to the top of the Peak. Certainly, there could scarcely be a watershed less exposed to contamination than this. Half way up the mountain is a printing office, where a daily paper is issued, which does not give a large amount of space to the foreign or domestic news, but does contain an accurate list of the names of those who make the ascent each day, with items of interest in regard to the incidents of daily travel. Descending at about 1.30 P. M., a good meal may be obtained at the station, and carriages may be taken for a drive to the Cave of Winds, the Garden of the Gods and other points of interest. The Cave of the Winds is said to be well worth a visit, but time did not allow us to take it in; instead we went to the Cliff Dwellings and the Garden of the Gods. The Cliff Dwellings are not located on their original site, but have been transplanted from Southwestern Colorado to their present location, where they have been reconstructed, stone upon stone. They are very interesting relics and give one an accurate idea of the mode of life of these wary tribes, who, like the conies, were but a feeble folk, yet they made their houses in the rocks. Nearby is a pueblo of recent construction, inhabited by Indians, who give exhibitions, as well as manufacture their wares for sale. For a few coins we were favored with a doleful dance, accompanied with a nerve-racking chant. The Garden of the Gods is a barren and picturesque tract of hill and dale, with many curiously-fashioned rocks, grotesquely resembling figures of animals, people and buildings. These rocks are of reddish color, and have been eroded by wind and storm until some of them are bal-

BALANCE ROCK, GARDEN OF THE GODS, MANITOU, COLORADO.

SUMMIT OF PIKE'S PEAK, COLORADO.

anced almost on a pivot, and look as if a puff of wind would blow them over.

A side trip of wonderful interest, which, however, I was not able to take, is to Cripple Creek, said to be the greatest gold-mining region in the world. The railroad goes boldly up and over the lofty mountains, and is of marvelous scenic beauty.

Leaving Colorado Springs on July 18, we took leave of sight-seeing and struck out for home, reaching Denver about 8 o'clock in the evening, and remaining only long enough to get a good dinner at a hotel near the station. Denver was brilliantly illuminated with electric lights and signs, probably on account of some convention that had been or was being held there. The next morning we were running through the rolling, highly-cultivated prairies of Nebraska, and reached Omaha in the afternoon. Having some time to spare, we took a ride into the city, which in a short and superficial inspection did not appear to be a very attractive place. Crossing the Missouri River on a high bridge, we passed through Council Bluffs and thence across the State of Iowa to Chicago. I had never been in Iowa before, and was agreeably surprised at the appearance of the country, which was attractive, with trees and water in abundance and the fields in a high state of cultivation. We reached Chicago early on the 20th, and took a Lake Shore train for New York. We were now in the decadent and effete East and were on more familiar ground, passing through Toledo, Sandusky, Cleveland, Buffalo and other cities on the shore of Lake Erie; thence through Syracuse and Utica, and along the line of the new Erie Canal, which is in the course of construction, to Albany; down the Hudson to New York, and a rapid transfer from the Grand Central to the new Pennsylvania Station, where we caught a fast train to a little, old, slow town called Baltimore, which we reached at 9.30 P. M. on July 21 after a trip crowded with delightful, interesting and instructive incidents and covering about 10,000 miles of the earth's surface.

As we came down from New York there were no hoary mountains in sight, but the grass was green, the lawns well kept and the homes pleasant to look upon, and when we passed Philadelphia and came to the splendid rivers of Maryland I was satisfied to remain in a land that is sometimes hot in summer and cold in winter, but, taken the year around, is veritably a land flowing with milk and honey. It is said that an Icelander when he returns to his native island exclaims: "After all, Iceland is the best country that the sun shines upon," and in the same spirit the traveler returning to the shores of the Chesapeake devoutly says, "Maryland, my Maryland!"

HYPEREMESIS GRAVIDARUM AND NEURITIS PUERPERALIS RESULTING AS A SEQUELA OR COMPLICATION, WITH REPORT OF A CASE.

By Edward Sooy Johnson,
Senior Medical Student.

Probably the commonest disorder of the digestive tract seen in pregnant and puerperal women is vomiting, occurring in one-third of all cases of pregnancy. This type of gastric disturbance

is divided into two great classes: (a) physiological or simple vomiting; (b) pathological or pernicious vomiting.

Simple vomiting of pregnancy is usually present during the earlier months, and ceases at the end of the fifth month. While causing distress, and ofttimes much discomfort, it does not seriously impair the nutrition of the pregnant woman; in fact, some multiparæ women have become so accustomed to it that they have learned to look upon it as a natural sequence during their respective pregnancies.

Pernicious vomiting, on the other hand, is a very serious condition, which may, if it resists treatment, place the woman's life in jeopardy. There are three chief divisions: (a) neurotic, (b) reflex, (c) toxemic.

Etiology.—The etiology of pernicious vomiting is indeed obscure. So many factors may contribute to the production of this condition that just what is the cause can rarely be stated.

Giles has pointed out that probably three factors enter into the predisposing causation of the vomiting of pregnancy, namely, (1) exalted nerve tension, (2) peripheral nervous irritation arising from the enlarged uterus, (3) an easy outlet of the exalted tension, namely, the vagus nerve.

By the exaggeration of any one or two of these factors pernicious vomiting may be produced.

Bearing these three factors in mind, the predisposing causes of pernicious vomiting may be summed up as follows:

(a) In primipara the distention of the uterus is accomplished with much greater difficulty, on account of the greater tonicity of the uterine muscular fibers.

(b) Pre-existing or co-existing diseases of the uterus, as metritis, endo-metritis and cervicitis; also such abnormalities as twin pregnancies and hydramnios.

(c) Diseases of other pelvic organs, as salpingitis, ovaritis or inflammation and engorgement of neighboring organs or structures, the liver, kidneys and brain being the most important sites.

(d) Pathological state of the alimentary canal, as gastric ulcer, dyspepsia, gastritis, etc., acting directly upon and increasing the latent stimulating forces of the sympathetic nervous endings in the stomach.

(e) Too frequent sexual intercourse.

(f) Hysteria, mental or physical shock.

(g) General disturbance in metabolism and toxic conditions of the circulating tissues of the body, such as uremia and sapremia, etc.

Probably the most important exciting cause of nausea and vomiting in pregnant women is physiological uterine contractions. The nerve supply of the uterus is chiefly derived from the ovarian and hypogastric plexuses of the sympathetic nervous system, which to a certain extent has an independent action, while in the medulla there is a center which presides over uterine contractions.

It is a well-known fact that the uterus is subject to rhythmical contractions throughout the whole period of pregnancy, and it is probable that the purpose of these contractions is to facilitate the circulation of blood through the uterine sinuses.

The enormous distention of the veins of the uterus which occurs as the result of pregnancy brings about a retardation of blood in the sinuses, and when the contraction of the uterine musculature begins, most all the blood is driven out, and thus the uterus may be said to supplement the action of the heart, to which it may, in a sense, be compared, since the nervous supply is also very similar in arrangement.

It must be admitted that in the development of the embryo and the marked changes that the uterus undergoes at this same time, many chemical changes must occur. It is from the venous sinuses at the placental site that the embryo derives its chief nourishment, and into which the residue (or ashes, as it were) are emptied.

Ordinarily, the circulation of the blood through the sinuses provides for the change in supply, but owing to the slowing of the blood current from dilatation of the sinuses, there may be a certain residuum, and as the blood becomes surcharged with this they probably act as irritants to the sympathetic nerve endings and stimulate the uterus to contractions, and thus to a certain extent the uterus may be said to empty itself.

It is these contractions, so brought about, which probably cause the paroxysms of nausea and vomiting. It is also probable that the nausea and vomiting which occur in 90 per cent. of cases in the morning is due to the engorgement of the pelvic circulation consequent to the change in posture. This change leads to excessive uterine contraction, and thus the peripheral irritation is increased. Now, if the patient partakes of a lit-

tle food before arising, a certain amount of this blood is retained in the stomach to carry on digestion, which might otherwise go to the pelvic area and subsequently be sufficient to cause the vomiting.

All of the above can only be classed as predisposing to pernicious vomiting, and the exact exciting cause of this dreaded disease is yet to be found.

Symptoms.—Ordinarily, pernicious vomiting begins as a simple nausea and vomiting of pregnancy, which gradually becomes so frequent and severe that nothing can be retained on the woman's stomach.

As stated above, Williams gives three distinct types, as follows—(1) neurotic, (2) reflex, (3) toxemic—with which we have to deal, and, unfortunately, the mere severity of the symptoms gives no clue as to the particular variety with which we have to deal.

In the reflex and neurotic types, the vomiting may continue for many weeks, and the patient becomes more and more emaciated, and finally dies of starvation if suitable treatment is not instituted.

In the toxemic variety, similar symptoms may exist for some time, and the true condition may not be recognized until the patient begins to vomit coffee-ground-like material, which she ejects in enormous quantities with but little or no apparent effort on her part.

Jaundice may or may not appear; the urine usually becomes greatly diminished in amount, and frequently shows albumin and casts in large numbers, though the latter (casts) in many cases are entirely absent. The urine frequently contains large quantities of blood, usually in the form of hematin crystals.

It was formerly taught that the temperature and pulse is always accelerated, but this is not the case, since the pulse has been frequently seen below 90 per minute and temperature subnormal.

The duration of pernicious vomiting is usually from two to three months, the nutrition gradually becoming poorer and poorer. Finally the patient dies of starvation.

Exceptionally the disease takes on a very rapid course, and after only a few days of ordinary vomiting the patient begins to eject blood-stained material and passes into a comatose condition and dies within a few days without any marked emaciation. In such cases death is evidently due to acute toxemia, and not to starvation.

Pathology.—Neurotic form: no cause found in urinalysis, and no pathological changes either found macroscopically or microscopically anywhere.

Reflex form: no pathological changes found in any organ, but investigation may reveal a tumor or other tissue formation sufficient to produce the nervous train of symptoms.

Toxemic form: largely determined by urinary analysis. The methods are very complicated, and often misleading and unsatisfactory. We also find, post-mortem, fatty degeneration of various organs and structures, the liver, kidneys and brain tissue being the principal structures involved.

Diagnosis.—Between neurotic and toxemic is by exclusion and by urinalysis. Between toxemic form and other forms is also by exclusion and urinary findings, amount of ammonia in relation to that of nitrogen being most important, normal ammonia coefficient being 4 per cent. to 5 per cent., and in toxemia of pregnancy we may have an increase of from 5 per cent. to 50 per cent.; 10 per cent. may be considered positive of toxemia.

Prognosis.—Good in reflex and neurotic types, but very grave in the toxemic form, the mortality being from 40 per cent. to 60 per cent. in all non-operated cases and from 20 per cent. to 30 per cent. in cases treated by the induction of abortion.

Pernicious vomiting occurs once possibly in every 800 cases of pregnancy, 80 per cent. of this number being primiparæ above the age of 25 years.

Treatment.—(1) Prophylactic, (2) dietetic, (3) curative.

Prophylactic: Restricted diet for two or three days at onset of any abnormal symptoms of digestive tract. Give liquid food by mouth or rectum. (2) Cut short intake of nitrogenous foods, meats, etc. (3) High blood pressure reduced if it exists. (4) Elimination by skin, bowels, etc., is very important. (5) In short, close observation by a competent physician during the pregnant state will reduce the mortality more than any other one thing.

Dietetic: Give one glass of milk every four hours with same amount of water, alternating each two hours. (2) If patient cannot take milk, give oysters, fish, green vegetables, rice (boiled). (3) At times you may substitute buttermilk, various

prepared milks and milk with certain effeyerscing waters.

Curative: (1) Diaphoretic water, potass. acetate in ℥ii doses t. i. d. (2) diuretics, saline purgatives, hot baths, etc. (3) Hemmeter recommends the following prescription: R.—Cerium oxalate, gr. xv; cocaine muriate, gr. iii; menthol, gr. xii; bis. subnit., ℥i; simple elix. q. s. ad. ℥vi. Sig.: ℥ss on empty stomach four times a day. (4) If above treatment fails and woman continues to get worse, induce labor at once.

Complicating and following hyperemesis gravidarum in a certain number of cases there develops a multiple neuritis with varying degrees of severity, bounded on the one hand by the mildest forms, in which there is present only pain, parasthesia, etc., in the distribution of a single nerve to the more severe forms, in which there are present paralysis, anesthesia, pain, trophic disturbances, and finally the most severe forms, which show involvement both of the peripheral and central nervous system.

The etiological factors governing the production of neuritis as result of pregnancy may be caused by any of the common agents that bring about inflammation of nerves at any other time, such as *alcohol,* drugs and other exogenous toxines, trauma, infectious diseases or extension of inflammation from neighboring structures.

These forms of neuritis do not differ in their histories from neuritis that occurs in the non-child-bearing individual.

The nerves chiefly involved are (1) those of the sacral plexus, (2) neuritis of nerves distant to the genital area (example ulnar), (3) a general multiple neuritis may follow, particularly in alcoholic subjects.

Lauray makes three divisions of multiple neuritis seen as result of pregnancy—(1) traumatic, (2) septic inflammations by extension, (3) infectious neuritis from distant nerves, and often of the spinal cord.

Below is given a very beautiful case of Korsakoff's syndrome, in which we have a patient with the most pronounced symptoms and signs of a severe case of multiple neuritis, with marked disturbance of memory for recent events, and also a disorientation as to time and place. From a very careful inquiry of her surroundings, habits, etc., chronic alcoholism can be absolutely excluded, and we must therefore acknowledge that in this case, at least, Korsakoff's syndrome can be caused by some other toxine than alcohol. Report of case is as follows:

CASE II.

Mrs. J. S., Westminster, S. C.; age 33; married; June 23, 1911.

Complaint.—Paralysis lower limbs; weakness and numbness upper extremities.

Family History.—Negative.

Past History.—Has always been healthy, although somewhat nervous; four healthy children; August, 1910, miscarriage; was sick four weeks; felt generally weak after same, but was able to look after her household.

Habits.—Absolutely negative to alcohol and drugs; very moderate as to coffee.

Menstrual History.—Normal.

Careful inquiry into her surroundings, etc., failed to reveal any possibility of a chronic or acute toxemia of external origin.

Present Illness.—Patient has never been really strong since her miscarriage in August, 1910, although she was able to look after her household duties. In the fall of 1910 she again became pregnant, and in December, 1910, she began to have vomiting spells, which occurred independent of diet. This condition gradually grew worse, and in January, 1911, patient became confined to bed on account of weakness, persistent and almost continuous vomiting.

In the early part of February, 1911, she was taken to Atlanta, Ga., to a hospital, where the uterus was emptied. She remained there about one month. Vomiting ceased, but from the history it appears that paralysis of the lower extremities was discovered. Moreover, the patient says that she has absolutely no memory of her condition or her surroundings from the time of the operation until the latter part of April. She remembers nothing about the operation; has no idea or remembrance of the special nurse who was with her over a month, of the doctors or the hospital. When she again realized her surroundings she felt as though she had been asleep, and that several years has elapsed since her sickness in January. At this time she realized for the first time that her limbs were paralyzed; experienced pain; numb, cramp-like feelings in her hands, fingers and forearms; pain and soreness in both legs. The two sides were symmetrically affected. Patient returned to her own home in the early part of March, where she was under the care of her physician until she came to the

University Hospital in the latter part of June, 1911.

Physical Examination.—Patient is very poorly nourished; white woman; seems to be in considerable pain; very emotional, crying almost constantly, which she says she cannot help; speech is normal; memory marked amnesia for recent events, patient being unable to remember the name of the hospital for even the shortest periods, the names of the nurses and doctors; a few moments after receiving nourishment denies having received the same, etc. For remote events, for occurences precceding her visit to the hospital in Atlanta, her memory is very good.

Examination of chest, abdomen and pelvis yielded negative results.

Urine.—Quantitatively and qualitatively normal.

Blood findings are all normal. Stool negative. Temperature normal.

Respiratory rate normal; pulse 100-110.

Motor Functions.—Complete flaccid paralysis of both legs; double foot drop; marked weakness both thighs; weakness of muscles of both forearms, grip being very weak. Atrophy of the muscles of all four extremities most marked in those which are paralyzed and in the weakest muscles.

Contractures of the flexors of the leg, which prevent extension of the legs on thighs beyond an angle of 140 degrees; contractures of the posterior leg groups, which prevent the flexion of the feet or the legs to an angle less than 110 degrees; both great toes are markedly flexed and held in this position by contracture of their flexor muscles. These contractures exist on both sides, but are slightly more marked on the left. Trunk muscles and diaphragm are normal.

No abnormal movements.

Co-ordination of upper extremities poor; of lower extremities not tested on account of paralysis.

Reflexes.—Tendo-achilles and knee reflexes absent on both sides; triceps present.

Epigastric present; plantar stimulation gives rise to excessive but delayed pain, with no plantar flexion of toes; Babinski's sign absent.

Rectal and vesical reflexes are normal.

Sensory Functions.—Upper extremities tactile, pain and temperature sense are somewhat obtunded over hands, and lower part of forearm most marked in the peripheral distribution of the radial nerves; muscle sense normal. Trunk showed no sensory disturbance.

Lower Extremeties.—Tactile, pain and temperature sense are markedly disturbed; disturbance of these senses varies from slight obtundations along inner side of thighs to more marked blunting with incorrect localization on outer side of thighs and inner side of legs to delayed transmission and almost complete anesthesia along the outer side, posterior aspect of legs and dorsum and plantar surfaces of feet; complete loss of muscle sense of toes.

Parasthesias.—Patient complains of numbness and tingling, burning and itching in all four extremities; more marked in the upper.

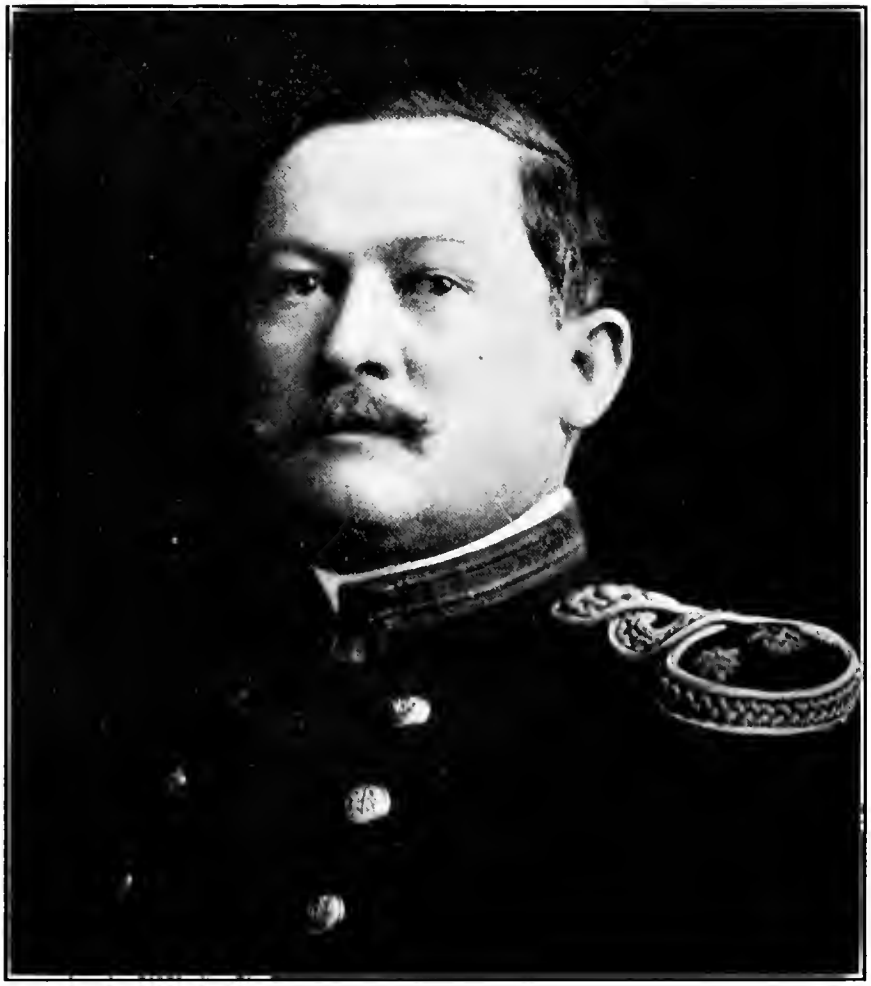
Nerves of upper and lower extremities are very tender to pressure; much pain of a burning, boring character complained of in all four extremities, more marked in lower.

Vasomotor and Trophic Disturbances.—The skin of both upper and lower extremities, especially in their peripheral portions, is constantly covered with a cold profuse sweat; is pale and mottled in appearance, and feels cold to the touch; nails of the toes are ridged and brittle.

Electrical Reaction. — Upper extremities, muscles all react to faradic current, requiring stronger currents than normal to bring about contraction of the small muscles of the hand; lower extremities, anterior thigh group react poorly to very strong current; anterior tibial group react to strong faradic stimulation of the nerve, but not to faradic muscle stimulation; all other muscles of lower extremities fail to react to faradic current, but respond more or less characteristically to galvanic stimulation.

Cranial nerves normal.

Diagnosis of Korsakoff's syndrome was self-evident, and patient was placed upon proper treatment. Her improvement has been progressive; left the hospital two months after her entrance very much improved; sleeps well; has increased in weight; no longer emotional; pains are no longer a source of discomfort; the use of the upper extremities for all practical purposes is normal; sensation and motion are gradually returning to her lower extremities; her memory for recent events is very much improved, and, in fact, is so good that it is almost impossible to discover any lapses. She returns to her home to continue treatment, and her complete recovery is now only a question of a few months.



DR. RUPERT BLUE

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BALTIMORE, FEBRUARY 15, 1912.

DR. RUPERT BLUE.

The virility of the University of Maryland has only recently been again attested in the selection of Dr. Rupert Blue, class of 1892, and D.Sc. (honorary), 1909, by President William Howard Taft as Surgeon-General of the Public Health and Marine Hospital Service. The appointment was won by noteworthy and meritorious service, which was especially evidenced in the suppression and eradication of bubonic plague in San Francisco in 1907. The part he played in creating a clean bill of health for the Golden Gate City brought Dr. Blue prominently before the public eye, and when the President was casting about for a man to fill the vacancy in the Surgeon-Generalship of the Public Health and Marine Hospital the executive ability of Dr. Blue as displayed in his various details was of such a meritorious character that of all the men in that branch of the Government service he was selected as the best fitted to direct its destinies for the ensuing four years.

Dr. Blue was born in South Carolina in 1868. He was graduated from the University of Maryland in 1892, and became an interne in the Marine Hospital Service during the same year. In the following year he was commissioned Assistant Surgeon, and in 1897 promoted to the grade of Passed Assistant Surgeon, and in 1909 to the grade of Surgeon. He was commissioned Surgeon-General of the Public Health and Marine Hospital Service January 13, 1912.

In 1903 and 1904 Dr. Blue was in charge of the Federal operations for the eradication of plague in San Francisco. In 1905 he took part in the suppression of yellow fever in New Orleans, and in 1907 was detailed as director of the sanitation of the Jamestown Exposition. In 1907 plague reappeared in San Francisco, and Dr. Blue was again placed in charge of the service work in California.

Dr. Blue recently spent some time in Europe studying preventive medicine as practiced there, and in 1910 graduated from the London School of Tropical Medicine. In May, 1910, he was detailed to represent the Public Health and Marine Hospital Service at the International Congress on Medicine and Hygiene at Buenos Ayres, and at this time took advantage of the opportunity to study possible routes by which plague and yellow fever might be imported into the United States from South America.

Dr. Blue's last detail before his appointment as Surgeon-General was at Honolulu, where he had been sent to act in an advisory capacity to the Hawaiian Board of Health and other departments of the Territorial Government in the carrying out of a program inaugurated to make the sanitary conditions such that the possibility of the introduction of yellow fever or plague into the Territory after the opening of the Panama Canal will be reduced to a minimum, and its spread, if introduced, impossible.

THE BULLETIN rejoices in the appointment of Dr. Blue, who ever since graduating has always been a credit to his Alma Mater, and extends to him, on behalf of the Regents, Faculty of Physic, alumni and undergraduates, their most cordial and heartiest congratulations on his well-earned promotion, and presage for him a successful and efficient administration.

"THE ANTS ARE A PEOPLE NOT STRONG, YET THEY PREPARE THEIR MEAT IN THE SUMMER."

The instinct of self-preservation is very strong, both in human beings and in certain of the lower orders of animal life. The squirrels industriously gather acorns and nuts, and lay them up for a time of need; the bees flit from flower to flower, and extract honey for future use, and we have it from the wise man of old that "the ants are a

people not strong, yet they prepare their meat in the summer."

In institutional life the same instinct ought to hold good. If the institution has justified its existence, and if its day of usefulness has not passed, it should take such measures as will insure its future. Most educational institutions, and especially medical schools, are like the ants—"a people not strong," and yet they must "prepare their meat in the summer" if they wish to prolong their lives. Medical colleges are not money-making institutions, and it is with great difficulty that they can meet their ordinary expenses; moreover, the cost of conducting such institutions is constantly on the increase, and the entrance requirements, as well as the qualifications for graduation, are being constantly advanced. This means either fewer schools or fewer students, or both. It cannot be gainsaid that both the number of schools and of students can be advantageously reduced. Every organization that has authority or influence in this direction is exerting its force to crush out the feebler schools, and to diminish the output of medical graduates. This means the survival of the fittest. We must look the issue fairly in the face. Have we justified our existence, and do we deserve to continue to exist? I must leave the question for others to answer. As an alumnus I think we have more than justified our existence, and that we should not permit our Alma Mater to perish for lack of sustenance.

The faculty is devoting its energies to the rehabilitation of the school, and its work is largely altruistic, but it is impossible for it to endow chairs, and it is only by the endowment of its scientific chairs that the future of the institution can be insured. Friends and fellow-alumni! we must look to you to aid us in this our time of need. The need is urgent, the summer is short.

The subscriptions to February 1, 1912, are as follows:

Robinson bequest	$5000 00
Dr. Hugh Hampton Young, J. H. U.	100 00
Prof. R. Dorsey Coale, Ph.D.	100 00
Dr. S. J. Meltzer, LL.D., New York	10 00
Dr. Gideon Timberlake	25 00
Dr. Gordon Wilson	50 00
Mr. H. P. Ohm	10 00
Dr. Samuel W. Moore, D.D.S.	25 00
Dr. A. Sagebein, D.D.S., Cuba	5 00
Thomas C. Basshor Company	10 00
Hospital Bulletin	10 00
Maryland Medical Journal	5 00
Miss C. M. Selfe	5 00
Mr. George Lewis, Florida	50 00
Mr. J. Henry Smith	25 00
Mr. R. A. Krieger	5 00
Summers Printing Co.	15 00
Williams & Wilkins Company	50 00
Geo. W. Walther & Co.	15 00
Muth Bros. & Co.	10 00
Dr. John J. R. Krozer, 1848	50 00
Dr. Eugene F. Cordell, 1868	10 00
Dr. John G. Jay, 1871	25 00
Dr. C. R. Winterson, 1871	10 00
Dr. Chas. H. Diller, 1872	20 00
Dr. Joseph T. Smith, 1872	10 00
Dr. W. J. Young, 1872	25 00
Dr. Isaac S. Stone, 1872	10 00
Dr. Thomas A. Ashby, 1873	100 00
Dr. David W. Bulluck, 1873	100 00
Dr. Robert Gerstell, 1873	5 00
Dr. Randolph Winslow, 1873	100 00
Dr. James W. Humrichhouse, 1873	25 00
Dr. H. T. Harrison, 1874	5 00
Dr. John D. Fiske, 1875	5 00
Dr. Wilmer Brinton, 1876	100 00
Dr. Wm. E. Wiegand, 1876	10 00
Dr. Thomas Chew Worthington, 1876	5 00
Dr. R. H. P. Ellis, 1877	10 00
Dr. L. Ridgely Wilson, 1880	5 00
Dr. Charles S. Mitchell, 1881	100 00
Dr. L. Ernest Neale, 1881	100 00
Dr. E. L. Meierhof, 1881	50 00
Dr. James M. Craighill, 1882	25 00
Dr. J. M. Hundley, 1882	250 00
Dr. Henry Chandlee, 1882	25 00
Dr. Charles C. Harris, 1883	10 00
Dr. Louis W. Talbott, 1883	25 00
Dr. B. Merrill Hopkinson, 1885	25 00
Dr. J. C. Perry, 1885	100 00
Dr. H. C. Reamer, 1885	10 00
Dr. Frank Martin, 1886	100 00
Dr. John R. Winslow, 1888	50 00
Dr. C. W. McElfresh, 1889	100 00
Dr. Joseph E. Gichner, 1890	25 00
Dr. St. Clair Spruill, 1890	150 00
Dr. Rupert Blue, 1892	100 00
Dr. Frank J. Kirby, 1892	50 00
Dr. Andrew J. Crowell, 1893	10 00
Dr. Walter B. Kirk, 1893	5 00
Dr. Martin J. Cromwell, 1894	50 00
Dr. Charles T. Harper, 1894	50 00
Dr. Henry Lee Smith, 1894	10 00

Dr. Harry Adler, 1895	100 00
Dr. Jose L. Hirsh, 1895	50 00
Dr. John McMullen, 1895	5 00
Dr. Joseph W. Holland, 1896	50 00
Dr. R. W. Sturgis, 1896	2 00
Dr. Robert H. McGinnis, 1897	5 00
Dr. Compton Riely, 1897	50 00
Dr. Guy Steele, 1897	15 00
Dr. Page Edmunds, 1898	50 00
Dr. Albert J. Bossyns, 1898	5 00
Dr. Edward E. Lamkin, 1898	25 00
Dr. L. W. Armstrong, 1900	10 00
Dr. S. Demarco, 1900	50 00
Dr. M. S. Pearre, 1900	5 00
Dr. Irving J. Spear, 1900	50 00
Dr. William Tarun, 1900	50 00
Dr. John Houff, 1900	25 00
Dr. Wm. H. Smith, 1900	25 00
Dr. J. D. Reeder, 1901	50 00
Dr. Nathan Winslow, 1901	50 00
Dr. Wm. R. Rogers, 1901	25 00
Dr. Frederick N. Nicholls, 1902	15 00
Dr. Arthur M. Shipley, 1902	250 00
Dr. H. C. Davis, 1902	10 00
Dr. H. L. Rudolf, 1902	25 00
Dr. Wilbur P. Stubbs, 1902	5 00
Dr. Hugh Brent, 1903	25 00
Dr. Louis B. Henkel, 1903	25 00
Dr. G. C. Lockard, 1903	25 00
Dr. Geo. S. M. Kieffer, 1903	25 00
Dr. H. J. Maldeis, 1903	25 00
Dr. Howard J. Iglehart, 1903	25 00
Dr. Howard W. Jones, 1903	25 00
Dr. John T. O'Meara, 1903	25 00
Dr. Fred L. Wilkins, 1903	25 00
Dr. Albert L. Wilkinson, 1903	25 00
Dr. R. C. Metzel, 1904	10 00
Dr. Ejnar Hansen, 1904	10 00
Dr. Charles Bagley, Jr., 1904	25 00
Dr. Alvin B. Lennan, 1904	25 00
Dr. Walter Van Sweringen, 1904	25 00
Dr. M. A. Weinberg, 1904	25 00
Dr. Herbert E. Zepp, 1904	25 00
Dr. Robert Bay, 1905	100 00
Dr. B. F. Tefft, 1905	100 00
Dr. Edward L. Bowlus, 1906	5 00
Dr. Joseph A. Devlin, 1906	10 00
Dr. W. F. Sowers, 1906	25 00
Dr. R. W. Crawford, 1906	25 00
Dr. Matthew L. Freilinger, 1906	10 00
Dr. Leo Karlinsky, 1906	20 00
Dr. J. F. Hawkins, 1906	25 00
Dr. Richard C. Hume, 1906	10 00
Dr. Frank S. Lynn, 1907	25 00
Dr. T. H. Legg, 1907	5 00
Dr. Albert H. Carroll, 1907	25 00
Dr. Edgar S. Perkins, 1907	25 00
Dr. W. Cuthbert Lyon, 1907	5 00
Dr. Thomas H. Phillips, 1908	25 00
Dr. J. N. Osborn, 1909	5 00
Dr. E. H. Kloman, 1910	25 00
Terra Mariae, 1911	3 50
Total	$9445 50

Additions for the month, $170.

ITEMS

Dr. John Randolph Winslow, class of 1888, announces the removal of his office to the Latrobe Apartments, Charles and Read streets, Baltimore, Md.

The theater benefit given by the Alumni Athletic Association of the University of Maryland at the New Academy of Music Wednesday, February 7, 1912, from a financial standpoint, was a success. Full report will occur in next issue. We take this opportunity to thank our friends who patronized the play.

At a recent meeting of the Howard County Medical Society the following officers were elected for the ensuing year: President, Dr. Frank Oldham Miller, class of 1902, and secretary-treasurer, Dr. Henry Dickinson Causey, class of 1911.

MARRIAGES

Miss Carlotta L. Shaefer, University Hospital Training School for Nurses, class of 1905, daughter of Mrs. Elizabeth Shaefer of 3103 Abell avenue, was married to Mr. Thomas F. Murphy of the Rocks, Harford county, Maryland, January 19, 1912, at the Cardinal's residence by Rev. F. D. McGraw. The bride wore a tan traveling suit and a corsage bouquet of violets. After the ceremony Mr. and Mrs. Murphy left for Atlantic City and a trip North. On their return they will reside at the Rocks.

Miss Bessie May Reid, daughter of Mr. and Mrs. Samuel M. Reid, was married January 17

at Brown Memorial Presbyterian Church to Dr. George W. Shipp, class of 1910, of Newton, N. C., by Rev. Dr. J. Ross Stevenson, the pastor. The bride wore a gown of heliotrope cloth and carried Bride roses.

The ceremony was attended only by the family and a few friends of the couple. After the wedding Dr. and Mrs. Shipp left for their future home in Newton, N. C., where the bridegroom is a practicing physician.

The marriage of Miss Louis Irene Craig, University Hospital Training School for Nurses, class of 1903, and Mr. James Upshur Dennis was solemnized January 20, 1912, at the chapel of Emanual Protestant Episcopal Church by Rev. Henry Evan Cotton, rector.

Mr. Samuel King Dennis, cousin and law partner of the groom, was best man, and Miss Margaret Dallas Craig, sister of the bride, was the maid of honor. The bride was given away by her cousin, Mr. Cassius M. Dashiell, of Princess Anne, Md.

The bride wore a dark blue traveling gown, with a hat to match, and carried lilies-of-the-valley. The maid of honor wore a charming gown of old rose tussah and a black picture hat, and carried Golden Gate roses.

The wedding was very quiet, no formal invitations or announcement having been issued, and only the near relatives of the two families were present. Mr. and Mrs. Dennis left immediately after the ceremony for a short trip.

Miss Craig is of the well-known Talbot county family of that name. Her father, the late Charles Page Craig, was a prominent business man of Cambridge, Dorchester county, where her brother, Mr. W. Grason Craig, and her sister, Miss Marguerite Craig, reside. Her mother (Irene Dashiell) was of the Dashiell family that has for many years been prominent in political and business life of the Eastern Shore, being a daughter of the late Nathaniel Dashiell of Somerset county, and a niece of the late Edwin Dashiell of Dorcheter county, as well as a niece of the late Hampden H. Dashiell, for many years Register of Wills for Somerset county.

Mr. Dennis spent his early life in Somerset county, but moved to Baltimore City about 20 years ago. He is a younger brother of Judge John Upshur Dennis of Baltimore, and a son of the late United States Senator George R. Dennis. He is a well-known member of the Baltimore bar, and was for a number of years secretary of the Maryland State Bar Association. For 10 years he has been a member of the faculty of the Baltimore Law School.

Dr. Rufus Clark Franklin, class of 1907, of Graymont, Ga., and Miss Wyney Coleman, daughter of Mr. and Mrs. J. A. Coleman, of Swainsboro, Ga., were married on Wednesday evening, January 17, 1912, at the residence of the parents of the bride.

The ceremony was performed by Rev. Crouse. The bridal party stood before an altar of handsome ferns. Just before the ceremony Miss Annie Mae Smith sang "The Rosary." The first to enter were the bridesmaids, Miss Madge McLeod and Miss Rosalie Bell, gowned in pink chiffon over pink satin and carrying pink carnations. They were followed by the dainty little flower girls, Misses Mattie Moring Mitchell and Marjorie Franklin, wearing frocks of pink crepe de chine. Master Graham Coleman was ring bearer.

The bride entered with her maid of honor, Miss Mabel Coleman, attractively gowned in white chiffon over satin, carrying a bouquet of white carnations. The bride was very attractive in her wedding dress of white satin with pearl trimmings. She carried a shower bouquet of white roses and valley lilies.

Dr. Franklin was attended by his brother, Mr. Paul Franklin, who acted as best man. The popularity of the young couple was attested by the large number of handsome presents.

Refreshments were served after the ceremony. Dr. and Mrs. Franklin left at 10 o'clock for a trip to Florida. On their return they will move to their home in Graymont, Ga.

Dr. Anton George Rytina, class of 1905, of 2204 E. Monument street, and Miss Catherine M. Gier of Baltimore were married in Washington, January 24, 1912. The ceremony took place at the Holy Comforter Church E. Capitol street, and was performed by the rector, Rev. Joseph A. Myer.

Miss Margaret B. Proudfoot, formerly an undergraduate nurse in the University of Maryland, of Goderick, Canada, was married to Dr. Joseph E. Thomas, class of 1911, of Tirzah, S. C., in Baltimore, February 7, 1912.

DEATHS

Dr. Harry Baldwin Gantt, class of 1880, of Millersville, Anne Arundel county, nephew of Rev. Dr. Charles W. Baldwin and Mr. Summerfield Baldwin, of this city, died at 9 o'clock January 20, 1912, at the Maryland University Hospital, where he had been since the early part of the week. Pneumonia is believed to have been the immediate cause of death.

In September Dr. Gantt cut his hand while operating upon a patient in Anne Arundel county. Blood poisoning developed in the arm, and he spent several weeks at the hospital. He returned to his home to resume practice, but was compelled to come to the hospital frequently for treatment.

About 10 days prior to his death pneumonia developed, and his physician again ordered his removal to the hospital. Here he was attended by Drs. Arthur M. Shipley, Lewellys F. Barker, Charles W. Mitchell and Gordon Wilson. Dr. Gantt's waning strength made it impossible for him to respond to treatment.

Dr. Gantt was 54 years old, and he crowded into that time many activities which brought him before the public in various ways. His father was the late Benjamin E. Gantt, a farmer, who became Register of Wills for Anne Arundel county, and also a member of the House of Delegates. His father was superintendent of the Sunday-school of Crossroads Methodist Episcopal (now Baldwin Memorial) Church for 25 years, and was a man of national reputation in the early campaigns for temperance.

The mother of Dr. Gantt was Miss Maria Eleanor Baldwin, the eldest child of the late William H. Baldwin of Millersville. Both she and her husband died many years ago. Dr. Gantt, their only child to attain maturity, was a student at Anne Arundel Academy, one of the most venerable and prominent schools in the State.

Having been graduated from the academy, Dr. Gantt, attended the University of Maryland Medical School, from which he received his degree as a physician in 1880. He became an assistant of the noted surgeon, Dr. L. McLane Tiffany, with whom he remained a considerable time.

Country life appealed to Dr. Gantt, and he began practicing at Millersville, his old home. He was married in 1884 to Miss Sue Adreon. Like his father, he was interested in the affairs of his county, and on the Republican ticket was elected Treasurer of the county about 10 years ago. He also served as a Delegate in the General Assembly.

He was employed as an emergency physician by the Washington, Baltimore & Annapolis Railroad Co., and took a marked interest in the development of good roads in the county. His genial, whole-souled nature, love of home and friends made him one of the most popular men within a radius of many miles. Several of his ancestors were distinguished Revolutionary soldiers.

Besides his widow, Dr. Gantt is survived by two sons, Dr. Harry B. Gantt, Jr., and Adreon Gantt, and three daughters, Mrs. J. Elizabeth Duker of Baltimore, Misses Sue Elizabeth and Margaret D. F. Gantt of Millersville. Mrs. Martha B. Morgan of Millersville is his aunt.

Dr. Charles Carfield McDowell, class of 1874, 60 years old, a well-known physician of this city, died at his home, 1521 W. Fayette street, January 24, 1912, after a lingering illness.

Dr. McDowell was born in New York State, and came to Baltimore when a boy. He received his early education in the public schools of the city and graduated in medicine from the University of Maryland in his early twenties. He practiced medicine in the coal regions of Pennsylvania for a short while, but later returned to Baltimore, where he continued the practice of his profession until a short time before his death.

The funeral took place from his home, Dr. H. A. Griesemer, pastor of Franklin Square Baptist Church, of which Dr. McDowell was a deacon, conducted the services. Burial was in Loudon Park Cemetery. He is survived by a widow (Mrs. Ella E. McDowell).

Dr. Louis W. Morris, class of 1885, of Salisbury, Md., died at his home on N. Division street, Salisbury, Md., February 2, 1912. Dr. Morris was the son of the late Dr. L. W. Morris of Princess Anne, and was 46 years of age. He is survived by his widow and one son—Louis W. Morris, Jr.—and two sisters—Mrs. C. W. Wainwright and Mrs. W. O. Lankford of Princess Anne.

Miss Edna Hedges, a pupil nurse at the University Hospital, died there of pneumonia January 24, 1912.

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CONTRIBUTORS TO VOLUME VII

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