# TRANSACTIONS

OF THE

# Homœopathic Medical Society

OF THE

## STATE OF NEW YORK,

FOR THE YEAR 1902.

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VOLUME XXXVII.




EDITED BY THE SECRETARY,
DEWITT G. WILCOX, M. D.
BUFFALO, N. Y.

**"A homœopathic physician is one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics.** *All that pertains to the great field of medical learning is his by tradition, by inheritance, by right."*—*President Eugene H. Porter, M. D., Feb., 1898.*

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*Rochester Democrat and Chronicle Print.*
1902.

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EASTERN DISTRICT—Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Otsego, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Warren, Washington—19.

MIDDLE DISTRICT—Allegany, Broome, Cattaraugus, Chemung, Chenango, Jefferson, Lewis, Livingston, Madison, Oneida, Oswego, Schuyler, Steuben, Tioga, Tompkins—15.

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| | |
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STATE BOARD OF MEDICAL EXAMINERS REPRESENTING THIS SOCIETY.

*To Serve Until 1904.*

JOHN B. GARRISON, New York, - - - Physiology and Hygiene.
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*To Serve Until 1905.*

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*To Serve Until 1903.*

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L. A. MARTIN, - - - - 74 Exchange St., Binghamton.

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G. W. ROBERTS, - - - - - - *To Serve Until 1903.*

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| | |
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| S. R. Snow, | Gynæcology. |
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| W. S. Mills, | Materia Medica. |
| P. W. Neefus, | Neurology. |
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| J. I. Dowling, | Ophthalmology and Otology. |
| E. H. Noble, | Pædiatrics. |
| D. G. Van Ostrand, | Public Health. |
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| M. O. Terry, | 196 Genesee St., Utica. |
| C. G. Capron, | 219 Genesee St., Utica. |
| A. R. Grant, | 366 Genesee St., Utica. |
| L. W. Dean, | 41 Gardner Bldg., Utica. |
| C. E. Chase, | 5 Winston Bldg., Utica. |

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| J. I. Dowling, | 223 State St., Albany. |
| Fred. D. Lewis, | 188 Franklin St., Buffalo. |
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| T. Parsons, | 33 Clinton Ave., S., Rochester. |
| C. A. Ward, | 33 Court St., Binghamton. |

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| | |
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| H. D. Cochrane, *Chairman*, | 59 Eagle St., Albany. |
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| R. F. Benson, Jr., | 2 St. Paul Pl., Troy. |
| W. F. Honan, | Broadway and 71st., New York, Mhn. |

# PROCEEDINGS

OF THE

## Fiftieth Annual Meeting of the Homœopathic Medical Society of the State of New York, Albany, N. Y., February 11th and 12th, 1902.

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The fiftieth annual session of the Homœopathic Medical Society of the State of New York was a pronounced success from every view-point. The character of the papers presented, the spirited discussion of the same, the resolutions adopted, looking toward a betterment of the profession and a closer guardianship of the public health were all high encomiums upon the progressive spirit of the Empire State Homœopathic Medical Society. Harmony, earnestness and progress were most noticeably present.

President John T. Greenleaf called the meeting to order at ten a. m.

Prayer was offered by Rev. Mr. Harwood.

DeWitt G. Wilcox, Secretary, read the minutes of the last meeting, as published in Vol. XXXVI. of the Transactions.

The Secretary also read the following editorial, which appeared in the Buffalo *Sunday News*, bearing upon said Transactions:

"From Dr. DeWitt G. Wilcox, the *News* has received a copy of the Transactions of the Homœopathic Medical Society of the State of New York for 1901. It is a big book, over three hundred pages. The fly leaf bears in black letters this definition: 'A homœopathic physician is one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics. All that pertains to the great field of medical learning is his by tradition, by inheritance, by right.' This utterance of Dr. E. H. Porter, President of the Society in 1898, is: 'Ordered printed conspicuously in the Transactions every year' and is significant. Its apparent meaning is that homœopathy stands for plus instead of minus, nowadays—the new school accepts the knowledge of the old and seeks to add to it. Science has won its inevitable victory in the field of medicine. The factions that were intent years ago on discrediting what each other knew are content to add each other's acquisitions to a common stock now. In this field of effort competition is succeeded by co-operation, or survived only in the form of rivalry in achievement. The world is better for homœopathy. It has moderated the old dosing and severe alterative treatment, external and internal. The world has

been good for homœopathy, too. It has taught its advocates the lesson that medicine has been slow to learn in all ages—that a single principle is not all of nature, and that all knowledge pertaining to life and death is vital to a just application of any theory to the cure of disease."

The following remarks were then made relative to the report:

F. PARK LEWIS: *Mr. President*, I move that the report be received and placed on file. I want to say in regard to the publication of the Transactions, that I believe we never have had a more complete and perfectly published volume than that which the Secretary has given to us as a result of our work in the past year. (Applause.) The completeness of the arrangement, the quality of the paper, the excellence of the print and the plan altogether of the arrangement, are such as to thoroughly commend the work which the Secretary has done. I want to say this in commendation; but after having said this much, I may be permitted to offer one suggestion without the Society or the Secretary considering it as critical, because we are all striving to get the best that we can. I have noticed that during all the previous years a number of pages in the back part of each volume has been occupied by what printers call very "fat" printing of records, of addresses and matters of that character which are mere references; and I would suggest that in future volumes it would add to the typographical excellence of the book, lessen the expense and be equally efficient if all of that matter were printed in smaller type, closer together.

## TREASURER'S REPORT.

W. B. Gifford, Treasurer, presented his report, which is as follows:

Homœopathic Medical Society, State of New York, in account with W. B. Gifford, Treasurer.

Dr.

| | | |
|---|---|---|
| By Balance received from Dr. Deady | $ 666.29 | |
| Cash received from dues | 1,130.00 | |
| Interest on deposits | 12.60 | |
| | | $1,808.89 |

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DISBURSEMENTS.

| | | |
|---|---|---|
| Cash paid by order DeWitt G. Wilcox, secretary, printing, postage and stenographer (stenographer, $95.00) | $ 358.57 | |
| Salary of secretary | 250.00 | |
| Printing and expressing Transactions | 628.17 | |
| Cash paid by treasurer, postage and printing | 40.58 | |
| Exp. semi-annual meeting | 10.35 | |
| Paid E. H. Porter, chairman committee on legislation, for printing and expenses | 93.80 | |
| J. L. Moffat, printing and postage | 12.00 | |
| J. L. Moffat, committee of provings | 83.33 | |
| Exchange on checks | 2.95 | |
| Cash on hand | 329.14 | |
| | | $1,808.89 |



Dr. Moffat suggested that the Treasurer, in presenting his report to the Society, make an itemized statement of all expenditures, particularly the stenographer's fees, and not merely include them in the general disbursements of the Secretary. Also to insist upon the members including in their remittances exchange on checks.

Dr. LeSeur said he thought the Treasurer's report was unusually satisfactory in the amount received. Dr. Gifford, the Treasurer, then mentioned that a large amount of back dues had been collected. The By-laws provide that members who are three years in arrears shall be dropped for non-payment and the Treasurer presents such list at each annual meeting. Dr. Gifford did not do so this year for the reason that quite a number of them could be gotten hold of and kept in the Society. He also mentioned the fact that there was $12.60 interest on the deposit of the State Society funds, which he had never seen in a previous report.

The President appointed the following committees:

*On Attendance.*—Howard P. Deady, Fred D. Lewis, C. H. Helfrich.

*Auditing Committee.*—C. A. Ward, F. Park Lewis.

PRESIDENT JOHN T. GREENLEAF gave a short but able opening address.

## PRESIDENT'S ADDRESS.

It is said that every age has its spirit, which may or may not be peculiar to that age alone, as history repeats itself from time to time. However this may be, all work both public and private, is more or less permeated by this peculiar spirit of the age in which the work is done.

It goes without saying that the spirit of the present age is one which fosters, leans toward and produces a tendency toward the centralization of power.

It is not the purpose of this brief paper to discuss the practicality or the reasonableness of this tendency, but simply to deal with it as it exists.

A good many years ago it was the plan of organization for physicians in the State of New York, that there should be a large central state organization, known as the State Society, that under its control and fostered by its influence there should be smaller societies in every county in the State.

These societies only connected with the larger organization by a delegate membership, had a legal status and power which gave them a position for licensing physicians, for looking into the general management of the health of the people in their county, for the redressing of wrongs and the doing of other work which seemed to be necessary to be done by a body of men, rather than by any one physician.

The tendency of the age, as above mentioned, has seemed to be toward the neglect, at least, if not the abolition of these smaller societies, and larger societies have been organized by the combining of a number of counties, in some cases quite a large district

having been admitted under the management of the new organization and these larger societies certainly tend to increase the interest of the meetings and prove beneficial to all who attend. The main objection to them is that they are entirely voluntary and have no legal status whatever.

With this change has come a tendency to the neglect of paying dues for delegate members and in many cases the county societies are entirely defunct; in fact, a report of the Treasurer would indicate that there are only eleven county societies remaining in organization and of these only five are paying dues.

This being the state of things, it occurs to your presiding officer that some arrangement should be made, either for the reviving of the old plan, or for its entire abolition. He recommends, therefore, that the matter be taken in hand and that all county organizations be abolished for the present, that no set of men be required to pay any dues to the State organization, as a body, and that of the 1,400 physicians in the State, a large number should be secured as members of the State organization. Whatever devices seem best to accomplish this end would be advisable and it is recommended that a committee be appointed, or elected, to take this matter in hand.

Another matter which it seems to your presiding officer requires attention is the fact that so few physicians are able to attend the annual meeting which is held in this place on the second Tuesday of each February. The objection to the place is that it is not central. The objection to the time is that it is at a season when physicians are most thoroughly occupied in their profession.

To obviate both, it is recommended that a committee be appointed to take the matter in hand, to change both the place and the time of meeting, and as a secondary matter, or corollary for the above proposition, it may possibly be well to look into the feasibility of having but one session a year instead of two, making it a little longer than heretofore.

The licensing power having been withdrawn from medical colleges and merged in a Board of Examiners and through their recommendation, in the Regents of the State University, it naturally follows that those gentlemen who act as examiners for our school hold positions of responsibility and honor among their brethren.

It may be noted that for the past six or seven years, during which time this plan has been followed, with excellent success, that only a very small number of men, comparatively, have been honored with this position. It may also be noted that a certain number have been continued in this capacity from the first of the carrying out of this arrangement.

If the position requires, as is reasonable to suppose, a great deal of hard work, it certainly should not be placed upon the shoulders of a very few men. If it is simply a place of honor, there are many outside of the number who have served on this board, to whom the honor is due.

It is, therefore, recommended that a resolution be passed, recommending to the Nominating Committee that it be hereafter arranged so that there be rotation in office for these positions.



## REPORT OF THE COMMITTEE ON PRESIDENT'S ADDRESS.

Your Committee has considered the three suggestions of the President and respectfully report as follows:

The movement to do away with our delegate memberships has been growing in force for several years and the action of the Kings and New York Counties Societies has brought this matter to a focus. Even if this Society had the legal power to collect these dues, the attempt to do so would lead to so much friction as materially to injure this Society and its influence. We, therefore, recommend that this report be considered a notice of amendment of the Constitution and By-laws, abolishing delegate memberships. Experience has demonstrated the importance of our meeting in Albany during the session of the Legislature; with due reference to the recommendation of our presiding officer, we deem it unadvisable to make any change in the time or place of our meetings. Our State Medical Examiners represent us better and more satisfactorily, other things being equal, the more experience they have. We recommend that nominations for this office be made upon the ground solely of fitness to discharge its functions.

JOHN L. MOFFAT,
GEORGE E. GORHAM,
J. W. LESEUR.

## REPORT OF THE COMMITTEE ON ATTENDANCE.

The Committee enrolled the following sixty-nine:

*Albany County*—J. Ivimey Dowling, S. H. Carroll, G. E. Gorham, E. T. Schwilk, B. E. Marshall, H. D. Cochrane, C. L. Bailey, Edward G. Cox, W. E. Milbank, Fred J. Cox, A. B. Van Loon.—11.

*Broome County*—C. A. Ward, L. A. Martin.—2.

*Cattaraugus County*—J. D. Zwetsch.—1.

*Cayuga County*—Chas. A. Gwynn.—1.

*Chemung County*—Frank H. DeCamp.—1.

*Chenango County*—C. N. Guy.—1.

*Columbia County*—C. P. Cook, Charles L. Mosher.—2.

*Dutchess County*—A. L. Peckham.—1.

*Erie County*—DeWitt G. Wilcox, F. Park Lewis, Fred D. Lewis.—3.

*Fulton County*—W. G. Garnsey.—1.

*Genesee County*—J. W. LeSeur.—1.

*Jefferson County*—E. A. Simonds, W. H. Nickelson.—2.

*Kings County*—H. D. Schenck, William M. L. Fiske, William Morris Butler, John L. Moffat.—4.

*Montgomery County*—L. A. Frazier, William M. White.—2.

*New York County*—C. H. Helfrich, A. W. Palmer, T. F. Smith, A. B. Norton, G. W. Roberts, Edward G. Tuttle, L. L. Danforth, J. W. Dowling, George A. Shepard, George W. McDowell, J. B. Garrison, Alfred Drury, E. H Porter.—13.

*Niagara County*—W. H. Hodge.—1.
*Oneida County*—C. E. Chase, M. O. Terry, A. R. Grant, C. G. Capron, C. T. Haines.—5.
*Onondaga County*—J. M. Keese, B. W. Sherwood, J. W. Candee.—3.
*Orange County*—Maurice C. Ashley.—1.
*Rensselaer County*—H. L. Waldo.—1.
*Saratoga County*—John A. Pearsall.—1.
*Sullivan County*—Howard P. Deady.—1.
*Schenectady County*—W. D. Spoor, H. L. Towne, W. P. Faust, Louis Faust.—4.
*Tioga County*—John T. Greenleaf.—1.
*Warren County*—S. T. Birdsall.—1.
*Washington County*—Lyman A. Clark, E. T. Horton.—2.
*Westchester County*—R. R. Trotter.—1.
*Wyoming County*—W. B. Gifford.—1.

## REPORT OF THE BOARD OF CENSORS.

The Board of Censors recommended the following thirteen, all of whom were elected permanent members:

| | ENDORSERS. |
|---|---|
| ARTHUR GINNEVER, M. D., Glen Cove, *I, 1901, | Geo. W. McDowell, G. W. Roberts. |
| WALTER GRAY CRUMP, M. D., New York, I, 1895, | Charles H. Helfrich, Herbert D. Schenck. |
| BENJAMIN RICHARD WHITE, M.D., Honeoye Falls, I, 1899, | Llewellyn J. Sanders, H. W. Hoyt. |
| G. DEWAYNE HALLETT, M. D., New York, I, 1889, | C. H. Helfrich, Herbert D. Schenck. |
| JOHN HUTCHINSON, M. D., New York, I, 1898, | Geo. F. Laidlaw, Wm. H. Van den Burg. |
| LEROY B. SHERMAN, M. D., New York, I, 1889, | A. Worrall Palmer, A. B. Norton. |
| GEORGE HILLS ILER, M. D., Brooklyn, I, 1890, | Herbert D. Schenck, John L. Moffat. |
| CHARLES S. WINTERS, A. B., M. D., Binghamton, I, 1890, | C. A. Ward, C. T. Haines. |
| WALTER GLOVER MEAD, M. D., Deposit, I, 1900, | C. A. Ward, L. A. Martin. |
| CHARLES W. TOWNSEND, M. D., New York, I, 1893, | C. G. Capron, Dewitt G. Wilcox. |
| T. DRYSDALE BUCHANAN, M. D., New York, I, 1897, | Thomas F. Davies, W. T. Helmuth, Jr. |
| AMELIA WRIGHT, M. D., Glen's Falls, 1, 1874, | Phoebe J. B. Wait, J. Edgar Ambler. |
| E. A. SIMONDS, M. D., Carthage, V, 1884, | W. S. Garnsey, W. H. Nickelson. |

* I. New York Homœopathic Medical College and Hospital.
II. New York Medical College and Hospital for Women.
III. Hahnemann of Philadelphia.
IV. Hahnemann of Chicago.
V. Chicago Homœopathic Medical College.
VI. College of Physicians and Surgeons, New York.
VII. University of the City of New York,—Medical Department.
VIII. Cleveland Homœopathic Medical College.



## REPORT OF THE COMMITTEE ON INCREASING INTEREST IN THE MATERIA MEDICA.

The response to our efforts has been so meagre and the criticisms of our report so adverse that it would seem advisable to form this committee next year of members who have not manifested any special interest in this subject; if they cannot tell us how they can be interested, to whom would it be logical to apply?

Dr. Myron H. Adams sent too late for our September report the following

VERIFICATIONS

that are fixed in his mind by many years of experience, quoting them from memory rather than copying them from a text book.

*Alumina.* Constipation, characterized by great inactivity of rectum with hard, round balls for stool. (Bry.)

*Argent. Nit.* Time passes too slowly; also indigestion, flatulence with sense of great distension; severe headache, often in occiput, with flatulent form of indigestion.

*Carbo Veg.* Belching of gas soon after eating, the same mixed with sour, rancid food. Great similarity to argent. n., only the latter has not the rancid, sour taste of food.

Respectfully submitted,
JOHN L. MOFFAT, *Chairman.*

## REPORT OF BANQUET COMMITTEE.

*Mr. President*: I would say that the banquet is to be held to-night at eight o'clock and the Committee has made arrangements to have it cost two dollars per plate.

EDWARD G. COX, *Chairman.*

## REPORT OF COMMITTEE ON NECROLOGY.

Your Necrologist has ready to hand to the Secretary, notice regarding the death of Dr. Charles Bonnell, Dr. Henry Von Musits, Dr. Henry Foster. Efforts have been made and are being made for reports concerning the deaths of Dr. H. C. Houghton, New York City; and D. A. E. Underhill, Brooklyn. (See Appendix.)

W. S. GARNSEY, *Necrologist.*

## REPORT OF THE COMMITTEE ON MEDICAL LEGISLATION.

DR. E. H. PORTER, Chairman, presented the following report:

*Mr. President*, If I am in order, I would like to make a brief report of the work of the Legislative Committee. This is not a tale of peace, gentlemen. This is a narrative of war. Last December I understood that the Governor had it in mind to recommend the abolishment of the boards of managers of the State asylums for the insane. Sometimes, when you want to know anything, the best way to do is to ask about it, so I went up and asked the Governor what

he was going to do. He smiled in that guileless fashion that sometimes characterizes him when he is asked questions that he does not altogether approve of, and said very succinctly that he was considering that very topic and proposed to make a recommendation to the Legislature, though no gentle art of persuasion that I could bring to bear upon our most estimable Governor would bring out of him what the recommendation was to be, so that I went away almost as wise as when I came to Albany. However, I went back to New York with a very distinct conviction that he was about to recommend the abolishment of the boards of managers. A short time after that a committee of some of our old-school friends came to me with a bill, which was an amendment of a bill that I had already prepared and submitted to them and some of our homœopathic friends, proposing a plan for the retention of the boards of managers, and a better division, as we thought, of the power of the Lunacy Commission and the power of the boards of managers. But before that bill could be introduced, or before the Legislature could be convened, we had certain information that the Governor's message was already written and that the abolishment of the boards was finally and fixedly determined upon. The bill abolishing the boards of managers, gentlemen, is what is known in our day and generation in political circles, as an administration measure. It means that the strong arm of the Governor is behind it. And when your Committee realized the state of affairs, we knew that we had an uphill fight; but it seemed to your Committee that there was just one thing to do. We were confronted by a condition, a serious condition, so far as our asylums are concerned, and for this reason we determined to fight to the end. In this fight our old-school friends did absolutely nothing. They lay on their oars. I have no fault to find with them if they did not think they were interested, because in their fights I have lain on my oars when it was none of my business, and I thought they could do their own fighting. When it came to something we were both interested in, we joined forces. In this particular instance they had nothing whatever to do with it. Only one of the New York medical journals, old-school, even noticed it editorially. *The Medical News* came out flatly and fairly against it. This was not a question of the abolishment of the boards. I did not care two straws whether the boards were abolished or not. That made no difference to me, as I saw it; but I did care whether in the abolishment of the boards the protection which they afforded to the continuance of our asylums as homœopathic institutions, was to be taken away at the same time. That was the question.

Now, as you know, the boards of managers had patronage. Senator Brackett claims we had a great deal of patronage. I speak now as one of the Pharisees, that is to say, one of the managers—we did, gentlemen—we had a great deal of patronage. We appointed the superintendent, and having appointed the superintendent and found a good one, as we did happen to at Gowanda, that was all the patronage we could expect to have for the rest of our natural lives, or terms. I say "natural lives" advisedly, because you know



in New York no office holder ever resigns. We also had the power to appoint a treasurer, and by virtue of a certain adminstration measure which was passed two years ago, for reasons—well, "for reasons," we had the power to remove a treasurer without a hearing. That is a very desirable and enjoyable privilege, to feel that you can remove a man from office without a hearing. But, as a matter of fact, it was one of those bits of patronage that you are not likely to exercise. That is all the power the boards of managers had; but the boards of managers being made up of adherents to the homœopathic law, appointed the superintendents of the homœopathic asylums, and in that way we acted as a barrier between the State Lunacy Commission and our institutions. With the abolishment of the managers the appointing power goes straight to Albany; it goes directly into the Lunacy Commission and into the hands entirely of allopathic physicians. This, gentlemen, is no reflection whatever upon Dr. Peterson, whom I know and very highly esteem, and I believe Dr. Peterson will be eminently fair. But who is to follow Dr. Peterson? What do we know about the policy of the Lunacy Commission in the future? and what do we know about their policy if influence is brought to bear upon them in the way of the patronage of that Commission? Those, gentlemen, were the questions that appealed to your Committee. We allied ourselves with the State Charities Aid Association, with the State Charities Board. We held correspondence with bodies all over the State. We sent innumerable telegrams. I got out a circular, which was done in just sixteen hours, in New York, written, printed and mailed to 1,200 doctors in that time. We came up from New York in a special car, those of us opposed to this thing. We had a hearing; filled the Senate chamber to overflowing, and if I do say it, although I am prejudiced a little, possibly, in this case, we completely floored Assemblyman Rogers and Senator Brackett, and drove them up against the wall. Nevertheless, they turned us down. We expected to be turned down. But before they turned us down, gentlemen, we shook the Senate of New York so that it took them some two weeks to get that bill passed. When one of the leaders of the Republican party in Brooklyn was approached about this bill and was forced into a corner regarding his support, he said that he believed the bill was vicious in principle, that the homœopaths had the right of it, that he would be glad to use his influence in their behalf; but there was a trial of a certain official of Kings County going on before the Governor, in which he was interested, and he did not wish to antagonize the powers. So the Republican from Brooklyn voted for the bill. The Democrats from Brooklyn, God be with them, voted for the right side of it. It was in one sense a party question. Now, in New York the genius of Brother Vreeland has invented a broiler, which runs along the seats of the cars. Those of us who ride in those cars go home with chilblains on our feet and blisters elsewhere. (Laughter.) That is, there is an evolution there through the survival of the fittest, since only the strong survive. I discovered in the Senate here a sort of similar political broiler. When a senator felt

the heat applied from the Capitol he voted the right way; and, gentlemen, the broilers were too much for us. We were totally unable to counteract the effect of that influence.

There will be another bill introduced affecting the remaining charitable institutions of the State, and which will tend to concentrate political power and patronage here at Albany. Perhaps this is too plain talk—I am a good Republican myself, but I am a Republican with homœopathic tendencies, and I do not think that that is good Republicanism which does not take care of the homœopathic school. (Applause.) Our Republican representatives from New York voted almost to a man with us. In Syracuse a great amount of work was done, and I am sorry to say that with Senator White at the head, that they were also found on the wrong side. In Rochester a great deal of work was done. Ogdensburg sent down representatives. Utica sent down a representation from the Board of Trade. General Terry did all he could. To mention names is invidious. I did not mean to mention any one; but Terry is so handsome that when you look at him you cannot help mentioning him.

In regard to the bill concerning osteopathy, we killed that immediately. I might say, gentlemen, that the homœopathic forces could have killed that alone. We could have killed this bill regarding our asylums alone if the Governor had kept his hands off, but you know the governor of a state has a mighty influence. If the Governor had not introduced that as an administration measure it would have had no more show in this Legislature of ours than a bill to move the capitol from here to the city of Hudson, not a particle more; and I want to say to you, gentlemen, that a majority of the senators who voted for the Brackett bill were convinced that we were on the right side; they were convinced that they were voting against public sentiment. I do not want to say anything ungracious—Senator White is a Cornell man—but there are some men that vote listening to hear the rumblings of the political chariot, the wheels of which they hope, will in their revolutions lift them to Lieutenant-Governorship chairs. I do not say that that is true in this case, but I was very much disappointed in Senator White.

Osteopathy was killed without much trouble; and now, gentlemen, in conclusion, we have lost this fight. We expected to lose it, but we made such a fight that we are going to protect our asylums. We have things in such shape that they will not dare to interfere with our vested rights, and I believe before long we will have our boards of managers back. For one, as I see it to-day, although, of course, I am liable to change my mind upon conviction to the contrary, I believe that a little later on this State is going back to its boards of managers. I believe it is going to give them some definite and fairly adjusted powers with the Lunacy Commission. I believe the people of this State want this thing, and I believe that what the people of the State want, sooner or later they are going to have.

Now, gentlemen, I want to thank this Society for the effective way in which you have supported your Committee. I do not know that I ever had such a response to an appeal as that circular brought.



Telegrams and letters poured into the legislators and other men in power in great numbers, and they had a great effect. It was really wonderful, the work our School did in this way, and your Committee feel very grateful for the support you gave them.

And, finally, I desire to say that, having served the State Society for four years as Chairman of the Legislative Committee, and done what little I was able to, I wish now to lay down the burden of this work. I have been very glad to do what I could for the cause of homœopathy. I shall always be glad to do so. But I should also be glad if hereafter you would call upon some one else to assume the burden and heat of the day. (Applause.)

The report was accepted. Dr. Martin moved that Dr. Porter receive the thanks of the Society for the work he has done and that he be requested to retain his position as Chairman of the Board. The following bill of expenses incurred on behalf of the Legislative Committee was ordered paid to Dr. Porter:

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|---|---|
| Printing | $ 48 50 |
| Typewriting | 25 00 |
| Postage | 24 00 |
| Postage | 10 00 |
| Telegrams | 15 00 |
| Addressing | 5 00 |
| Expenses for trips | 75 00 |
| TOTAL | $202 50 |

## REPORT OF THE COMMITTEE ON STATE MEDICAL EXAMINERS.

*To the Homœopathic Medical Society of the State of New York:*

The State Board of Medical Examiners representing your Society would respectfully report as follows:

As is now customary, four examinations were held during the academic year, for which fifty-eight candidates appeared. Fifty-two were successful and six rejected (10.4%).

The Old School Board examined 671 candidates, rejecting 139 (20.7%) and the Eclectic Board had twenty candidates, rejecting five (20%). A total of 6,349 candidates have been examined under the State licensure system, of whom 1,379 (21.7%) were rejected. The average percentages of rejections for this period were as follows:

Homœopathic Board, 16.2%.
Old School Board, 22.08%.
Eclectic Board, 24.5%.

Under exemptions in the medical laws the Regents licensed during the year ninety-seven physicians.

On recommendation of the Homœopathic Board three diplomas were endorsed.

On recommendation of the Old School Board fourteen diplomas were endorsed.

On recommendation of the Eclectic Board two diplomas were endorsed.

The past year has been particularly busy and eventful. The personnel of your board underwent noteworthy change by the resignation of Dr. Asa Stone Couch. Dr. Couch had, from its inception, served as president of the Homœopathic Board and was also, from the first, president of the joint boards of medical examiners. He may truly be called a pillar of the system of State licensure and in relinquishing those duties he has terminated a cycle of long and most distinguished service for the profession.

A vacancy still remains in the Homœopathic Board. Dr. Everitt Hasbrouck of Brooklyn, was, on December 19, 1901, appointed by the Regents but, owing to ill health, declined to serve. It is expected that another appointment will be made at the next meeting of the Regents, probably in March. In this connection it may be well to call the attention of the Society to the desirability of selecting *eligible* alternative nominees in order to avoid embarrassment in filling vacancies.

The full board convened twice during the year. The first occasion was in New York, October 16, 1901, at which time a special meeting was held. At the same place and date they met in joint session with the Old School and Eclectic Boards and subsequently, also on that day, occurred a formal conference of the joint board with the medical council and the secretary of the Board of Regents. The annual meeting took place on February 11, 1902. There were also three meetings at which your board was represented, 1—a conference in New York, May 13, 1901; 2—a hearing at Buffalo, July 8, 1901, and 3—a meeting of committee on reciprocity of the joint board in New York, October 16, 1901.

The officers of the examining boards, the medical council and the secretary of the Board of Regents were invited to participate in the conference of May 16th. The President and Secretary of the Homœopathic Board were in attendance. Recommendations to the Regents were made: 1—That a practical test be given to the plan of divided examinations; 2—that better methods for identification of candidates be required in the examinations, including the furnishing of photographs of candidates. It was also advised that the legislative committees of the three State societies secure amendment to the laws permitting New York medical schools to admit to the second year graduates of colleges registered by the Regents as maintaining a proper standard in medical preparatory studies.

At the special meeting of the Homœopathic Board the resignation of Dr. Couch was accepted and resolutions of regret and esteem for the retired president adopted. Dr. J. M. Lee was elected president. Consideration was given to important matters pending before the board and a full discussion of the topics to be acted upon in joint meeting.

The three State boards of medical examiners in joint session further honored Dr. Lee by choosing him for their presiding officer. Resolutions of respect for former President Couch were adopted.



Attention was called to certain criticisms of the examining boards for not prosecuting violations of the medical law, which action is without the province of these bodies and rests with the local medical societies. The following formally announced topics were considered:

1. Divided examinations.
2. Arrangement of topics.
3. Work of the questions committee.
4. Safeguards in examinations.
5. Reciprocity in medical licensure.
6. Per diem allowance for members of committees.
7. Should the law be amended to regulate medical ethics and to define the practice of medicine?

Results of experience with the first divided examination were given and it was "*Voted*, That the conference request the legislative committees of the several State societies to secure an amendment to the law whereby students at least nineteen years of age who have met the preliminary education requirement may be admitted to the examinations in anatomy, chemistry and physiology and hygiene; also a further amendment whereby an allowance of one year in term of medical study may be granted to graduates of college courses registered by the Regents as entitling thereto."

The work of the question committee underwent review in a free discussion of the preparation and grouping of questions.

Additional safeguards are now thrown about the examinations in accordance with recommendation made at previous conference. Greater care on the part of the Regents in scrutinizing the moral character of applicants for license was also suggested.

In debating the topic reciprocity, it was evidently the sense of those most conversant with the subject that the outlook at present is not encouraging. Certain constitutional provisions act as a barrier in some instances. The following was adopted: "*Resolved*, That this conference is in full accord with any effort which will result in reciprocity in medical licensure between the several states, provided the present standard of medical education in New York State be maintained."

It having been shown that the expenses of members of the questions committee exceed their remuneration, it was recommended that a per diem allowance of $10 and expenses be granted to members of this committee when regularly in session.

Under the seventh topic was given a résumé of a case that had come before the Homœopathic Board. No action was taken under this order of business.

The conference of the joint board, the medical council and Secretary Parsons turned chiefly upon the question of rearrangement of topics and that of reciprocity. The first named proposition was debated at length and appeared to develop a determined effort to effect such change. Various recommendations for rearrangement were submitted, no two advocates agreeing, however, save in one particular—desire to disintegrate the distinctive department of the

examinations—therapeutics, practice and materia medica. The following scheme, one of several that were presented, will serve as an illustration: "Anatomy and physiology, hygiene and chemistry, pathology, internal medicine and diagnosis, obstetrics, surgery, therapeutics and materia medica." Unwilling to jeopardize the status of the distinctive schools of medicine, your representatives withheld their approval of the plan, as did also the eclectics. Discussion ended with adoption of the following resolution: "That the medical council be requested to prepare an amendment to the law covering a satisfactory rearrangement of topics for examinations, such rearrangement not to increase the number of papers now required; that this proposed amendment be sent to the secretary of each board of medical examiners, who shall ascertain the individual opinion of each member and report to the Regents' office; that if the vote be unanimous the legislative committees of the State Societies be urged to include this with other amendments for presentation to the next Legislature."

It may be here noted that subsequently an expression from at least the Homœopathic Board was gained by means of a circular letter from Dr. Raymond, president of the Medical Council, sent to each member, inviting statement of his views with reference to rearrangement of topics. None of the homœopathic examiners favored the measure and no further step appears to have been taken.

The reciprocity question was taken up and a committee of three from each examining board appointed to promote the same. The homœopathic representatives are Drs. Butler, Candee and Gifford with President Lee, *ex officio*.

Following adjournment the committee on reciprocity met and took action as follows: "*Voted*, That arrangements be made at once through the Regents' office for securing the attention of the Pennsylvania State Board of Medical Examiners to a plan for reciprocity in licensure, the initial step being to invite the appointment of a similar committee by the Pennsylvania board and to arrange for an early joint meeting."

Two cases, one involving the legal right of a certain physician to practice in this State, the second, the expediency or necessity of issuing a license to a candidate who is educationally well qualified but otherwise unfit, occasioned a vast amount of correspondence and other special work by the members of this board during the past year. In connection with the latter case a hearing was given at Buffalo, July 8th, before the officers and others of the board.

At the annual meeting held February 11, 1902, at the Regents' office, Albany, the following were present: President Lee, Drs. Gifford, Butler, Candee and Garrison; also Secretary Parsons and Mr. Frederick Wadhams, counsel for your Society.

Several proposed amendments to the medical law were freely discussed. Further consideration of these measures was advised.

Officers for the ensuing year were elected as follows: President, Dr. J. M. Lee. Secretary Dr. J. W. Candee.



The following was adopted:

*Resolved*, That it is the judgment of this board that a reasonable degree of leniency should be shown in the examinations in anatomy, physiology and hygiene and chemistry in the cases of candidates who have had long experience as reputable practitioners, and that the secretary be asked to confer with other boards to see how this may be brought about without amendment to the law.

JOHN M. LEE,
President.

JAMES WILLIS CANDEE,
Secretary.

## MISCELLANEOUS BUSINESS.

On motion of Dr. Schenck, the amendment of Article I, Section 6 of the By-Laws, offered by Dr. Moffat at the last annual meeting, changing the method of electing officers to read as follows, was adopted:

Any ten members may certify to the Secretary on or before December 15th of any year, nominees for any or all elective offices to be filled at the next annual meeting.

On or before January 1st in each year the Secretary shall send to each member a list of nominees so certified to him and a ballot providing for nominations for the officers to be elected at the next annual meeting.

On or before January 25th the Secretary shall send to each member a ballot made up of the two nominees for each office, provided such nominees shall have signified to him their acceptance of such nomination, who have received the highest number of votes previous to January 15th. Each member shall indicate his choice by a cross prefixed to one nominee for each office. The ballot shall be unsigned and sealed in an envelope marked "ballot" furnished by the Secretary, which shall be enclosed in an envelope endorsed by the member's name and address. A ballot shall be counted only in so far as it is marked in accordance with the above.

The polls shall close on February 5th. The ballots of members certified by the Treasurer as being in good standing shall be opened and counted only, in the presence of three tellers on or before the first day of the annual meeting. After canvassing the ballots the tellers shall certify the result to the President on or before ten a. m. on the second day of the annual meeting.

In case the nominees for any office fail to receive a majority in the ballots cast previous to the annual meeting, open nominees for such office or offices shall be made at eleven a. m. on the second day of the annual meeting and balloting continued until a nominee receives a majority vote.

Three tellers shall be appointed by the President before February 1st of each year.

Dr. Schenck gave notice that at the next annual meeting he would offer an amendment to Articles II., III., and VII. of the Constitution

which simply provides for the amendment of the Constitution and By-Laws in accordance with the above resolution and in accordance with the discontinuing of the delegate members any longer.

On motion of Dr. Smith, twenty-five dollars was voted to be paid to the Chairman of the Banquet Committee to make up deficit.

The Treasurer was also ordered to pay the janitor of the City Hall ten dollars.

The Secretary read two communications from the Kings County and New York County Societies, mentioning the withdrawal of their delegate members. On motion of Dr. Schenck they were referred to the Committee on President's Address. (See Committee on President's Address.)

President J. T. Greenleaf appointed C. A. Ward, H. P. Deady and A. W. Palmer as a Committee to Nominate the Committee for Nominating the Candidates for State Medical Examiners. They reported the following names, all of whom were elected: George W. Roberts, L. A. Martin, F. Park Lewis, H. D. Schenck, Charles T. Haines.

Dr. Greenleaf appointed the following tellers: For the election of officers, Charles A. Gwynn and J. Ivimey Dowling. For the election of candidates for medical examiners, M. C. Ashley and Fred Lewis.

The election resulted as follows,

President—JOHN L. MOFFAT, 1136 Dean St., Brooklyn.

First Vice-President—MAURICE C. ASHLEY, Middletown.

Second Vice-President—BUKK G. CARLETON, 75 W. 50th St., New York.

Third Vice-President—CHARLES A. GWYNN, 13 Grover St., Auburn.

Secretary—DEWITT G. WILCOX, 597 Elmwood Ave., Buffalo.

Treasurer—FREDERICK J. COX, 109 State St., Albany.

Necrologist—W. S. GARNSEY, 93 North Main St., Gloversville.

Counsel—FREDERICK E. WADHAMS, Esq., 33 Tweddle Building, Albany.

Censors—W. H. VAN DEN BURG, New York City, (S.); J. A. STEWART, Brooklyn, (S.); I. TOWNSEND, New York City, (S.); A. B. VAN LOON, Albany, (E.); J. I. DOWLING, Albany, (E.); W. S. GARNSEY, Gloversville, (E.); W. H. NICKELSON, Adams, (M.); C. A. WARD, Binghamton, (M.); J. M. KEESE, Syracuse, (M.); W. H. HODGE, Niagara Falls, (W.); G. T. MOSELEY, Buffalo, (W.); J. D. ZWETSCH, Gowanda, (W.).

Thirty-eight ballots were cast for State Medical Examiners which resulted in the following nominations:



To take the place of WILLIS B. GIFFORD and WILLIAM M. BUTLER —WILLIS B. GIFFORD, (34). WILLIAM MORRIS BUTLER, (32). WILLIAM M. L. FISKE, (32). MARTIN BESEMER, (17). E. H. NOBLE, (15). E. E. SNYDER, (10).

To take the place of ASA S. COUCH, resigned—J. W. LESEUR, (30). H. W. PAIGE, (24). H. D. SCHENCK, (11).

The following names were sent to the Regents for appointment: W. B. GIFFORD, W. M. BUTLER, W. M. L. FISKE, MARTIN BESEMER; J. W. LESEUR and H. W. PAIGE.

WM. M. BUTLER and W. B. GIFFORD were appointed by the Regents to succeed themselves and GEO. E. GORHAM, eligible by a former election, was appointed to fill the vacancy caused by the resignation of ASA S. COUCH.

Frank E. Caldwell, Brooklyn, presented his resignation, which was accepted.

M. O. Terry was elected a Senior member. The Secretary also read a communication from G. L. Gifford, of Hamilton, who desired to be made a Senior member. Same was referred to a committee.

Dr. Butler made a motion that the bill of Fred. E. Wadhams, Counsel, be paid when presented. Motion adopted.

M. O. Terry invited the Society to hold their semi-annual meeting in Utica. It was referred to the Executive Committee.

The following delegates were appointed to the Interstate Committee of the American Institute of Homœopathy: George W. Roberts, J. W. Sheldon.

Dr. Moffat made a motion that the recommendations contained in Dr. LeSeur's paper on "Vaccination" be referred to a special committee to report at their early convenience.

Dr. Moffat offered the following resolution:

*Resolved*, That in the opinion of this Society, if and when the State or local authorities enforce vaccination, they are in justice bound to surround it with all the modern safeguards;

*Resolved*, That public vaccinators should properly apply an efficient shield immediately upon vaccination, with instructions as to its removal;

*Resolved*, That the virus used by them should in each patient be free from all possibility of contamination.

The above resolution was also referred to the committee appointed to consider Dr. LeSeur's recommendations, which reported as follows:

The committee appointed to consider J. L. Moffat's resolutions would respectfully recommend the adoption of all three of the resolutions.

THOMAS FRANKLIN SMITH,
J. W. LESEUR,
L. A. MARTIN,
*Committee.*

Dr. Lee moved that the report be tabled. Carried.

The following program was presented:

## FIRST DAY—MORNING SESSION—10:45 A. M.

### BUREAU OF MATERIA MEDICA.

WALTER T. CRUMP, Chairman, absent. The Secretary read the following papers by title:

"Belladonna," by WALTER S. MILLS.

"The Seductiveness of Combinations," by ALFRED DRURY.

"Re-provings of the Homœopathic Materia Medica Should represent Artificial Disease," by H. M. PAINE.

### BUREAU OF LARYNGOLOGY AND RHINOLOGY.

H. W. HOYT, Chairman, absent. F. PARK LEWIS in charge. Two papers presented.

"Relation of Lymphoid Hypertrophy to the General System," by F. PARK LEWIS.

"Catarrhal Preventives," by FRED. D. LEWIS.

### BUREAU OF PUBLIC HEALTH.

HOWARD P. DEADY, Chairman, presented three papers:

"The Public Health, a Sarcasm and Suggestion," by LYNN A. MARTIN.

"Vaccination," by JOHN W. LESEUR.

"Colorado; Winter Sunshine," by F. A. FAUST.

### BUREAU OF SURGERY.

HOMER I. OSTROM, Chairman, absent. A. B. VAN LOON, in charge, presented five papers:

W. E. MILBANK presented some cases of Lupus.

"Further Observations on the Value of the Medicated Galvanic Current on Various Growths," by M. O. TERRY.

"Modern Anæsthesia," by ANSON B. BINGHAM.

"Ulcers of the Leg." by A. R. GRANT.



"Resection of the Metatarso-phalangeal Joint," by DEWITT G. WILCOX.

"The Surgical Treatment of Dysmenorrhœa," by HOMER I. OSTROM.

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## FIRST DAY—AFTERNOON SESSION—2:30 P. M.

### BUREAU OF OBSTETRICS.

FRANK W. ADRIANCE, Chairman, absent. W. S. GARNSEY, in charge, presented four papers:

"Rupture of the Fallopian Tube and Artery at Full Term and Immediately Preceding Labor," by F. P. WARNER.

"Uremic Eclampsia; Some Facts and Observations," by ARTHUR P. POWELSON.

"Placenta Prævia, Uræmia, Grippe; A Combination Case," by GEORGE R. STEARNS.

"Pemphigus Complicating Pregnancy," by W. S. GARNSEY.

### BUREAU OF PÆDIATRICS.

H. E. MERRIAM, Chairman, absent. DEWITT G. WILCOX, in charge, presented one paper:

"The Effect of Regents Examinations upon Nervous Children," by DEWITT G. WILCOX.

### BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

ALTON G. WARNER, Chairman, absent. CHARLES H. HELFRICH, in charge, presented two papers:

"The Eye Complications of Measles," by CHARLES H. HELFRICH.

"The Ear Complications of Grippe," by J. IVIMEY DOWLING.

### BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.

CHARLES A. WARD, Chairman, presented three papers:

"A Remarkable Cure with the Single Remedy in a Single Dose Given High," by GEORGE E. GORHAM.

"Diphtheria and Antitoxin," by C. GRAY CAPRON.

"Uricacidemia," by CHARLES A. GWYNN.

SECOND DAY—MORNING SESSION—10:15 A. M.

**BUREAU OF NEUROLOGY.**

GEORGE F. ADAMS, Chairman, absent. M. C. ASHLEY, in charge, presented two papers:

"Neuritis," by WILLIAM MORRIS BUTLER.

"Acromegaly; A Case" (with illustrations), by MAURICE C. ASHLEY.

**BUREAU OF GYNÆCOLOGY.**

GEORGE W. ROBERTS, Chairman, presented one paper:

"The Physical Signs and Treatment of Gonorrhœa in Women," by L. L. DANFORTH.

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# REPORT

OF THE

BUREAU OF MATERIA MEDICA.

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## BELLADONNA.

BY WALTER SANDS MILLS, M. D.,
Physician to the Metropolitan Hospital, Blackwell's Island;
to the Hahnemann Hospital, Out-patient Department,
NEW YORK CITY.

Belladonna, commonly called deadly night-shade, is one of the oldest known of medicinal plants. It is native to central and southern Europe. Its intoxicating and poisonous properties have been known for centuries.

Provings of belladonna were among the earliest made by Hahnemann. Since then it has been one of the most valuable remedies in the homœopathic materia medica.

There is a typical belladonna condition which is not easily mistaken. The patient is drowsy, he has a flushed face, bright, shining or congested eyes, hot skin, high temperature, and full, accelerated pulse. This combination of symptoms may be met with in the beginning of many different acute diseases. Whenever found, belladonna is the remedy.



In the grippe prevailing in New York City during the winter of 1900 and 1901, this group of symptoms was frequently met with. Perhaps scarlatina and tonsillitis most often present typical belladonna symptoms in their initial stages. In scarlatina belladonna must be followed by some other remedy. In belladonna sore throat this remedy will frequently cut short the disease in a few hours.

The delirium of belladonna is the result of active congestion of the brain, and is associated with flushed face, congested eyes, and rapid pulse.

I have records of several cases of facial neuralgia cured by belladonna. The remedy acted as quickly as any anodyne possibly could have done.

Case I.—A married woman, aged thirty-five, of gouty diathesis. She was subject to attacks of facial neuralgia and of acute gout. On March 3, 1894, she sent for me after having suffered paroxysms of acute pain for twenty-four hours. The pain followed the mental and the supraorbital branches of the trifacial nerve on the right side. During the paroxysms the patient could not close the teeth because they were so sensitive. Between the paroxysms the teeth were not sensitive. The pains were aggravated by hot applications.

My first prescription was aconite, which had no effect whatsoever. A few hours later a second prescription was made of belladonna, third centesimal. The patient and her husband both begged that morphine be given, but she did not get it. The first dose of belladonna stopped the pain in a few minutes. There was no return until July 29th following, when the same symptoms in somewhat milder degree developed. Belladonna, third, again relieved at once. There was a slight recurrence a few hours later. After that and until I left Stamford, two years later, she never had another attack.

Case II.—A similar condition to the above, but on the left side of the face. This patient was also a woman of about thirty-five, who was treated in August, 1897. Belladonna, third, relieved this case promptly.

Belladonna has a hacking cough, found most often in acute bronchitis. Usually it is associated with flushed face. The effort of coughing produces a throbbing headache. Occasionally a phthisical subject will exhibit a belladonna cough, but only in an active stage of the disease.

Belladonna will be found a useful remedy in localized inflammations in any part of the body. I have records of a number of cases of toothache from decayed teeth, where the cheek was swollen and hot, and there was a rise in temperature with full, rapid pulse, promptly relieved by that drug.

Belladonna is useful in acute gout, when the great toe is swollen, inflamed, and exquisitely tender.

Another condition where belladonna is useful is in the onset of appendicitis. Hale (Practice of Medicine) says that belladonna and mercurius are the only remedies that he has found of much value in this disease. I have a record of one case where belladonna alone relieved every clinical evidence of appendicitis in a young man of twenty-five, within eighteen hours. This was in July, 1895, and there has been no recurrence.

Another case was that of a young woman of twenty-two. She had two acute attacks of appendicitis at intervals of a few months that kept her in bed for some time, the last in March, 1898. Both of these attacks were treated by the family physician. In August, 1898, she suffered more or less for the entire month with what I finally diagnosed as chronic appendicitis. Belladonna alone helped her some, but not so much as belladonna in alternation with mercurius dulcis. As the symptoms did not become unbearably acute surgical counsel was refused by the patient although it was asked for. She eventually recovered and married.

A third case occurred in January of this year at the Metropolitan Hospital. The patient, a woman aged twenty-one, was delivered of twins, January 17th. On the 19th her temperature started up, reaching 102 4-5 on the 22nd. Careful examination showed normal lochia with very slight odor. The only tenderness was in the region of the appendix, and there was distinct rigidity of the abdominal muscles of the right side. Two bichloride douches, an enema, and belladonna brought the temperature to normal in a few hours. I believe the remedy helped.

Belladonna is useful in profuse menstruation, when the patient exhibits the characteristic facial expression of that drug. I have used it successfully a number of times in that condition. The patients were young and vigorous women who had excessive flows of bright red blood. In each case it was the first menstruation after confinement and several months nursing.

To sum up, belladonna is an extremely valuable remedy. There are many conditions where it is of service that have not been mentioned in this paper, but my object has been to speak of nothing that I have not verified many times.

Just a word as to potency in the use of belladonna. For several years I used the tincture, my favorite potency now is the third centesimal dilution. The change is the result of experience.

I have so often seen the temperature rise after prescribing belladonna that I have come to regard the drug as the cause. When I find the temperature going up after prescribing belladonna I stop the remedy and give a placebo. The temperature nearly always comes down. This is the only drug that I believe I have actually seen cause a rise of temperature.

Belladonna, if used judiciously, stopping at the proper moment, will promptly relieve the condition prescribed for. If the remedy is too long continued the case is aggravated and the patient is worse off than before.



# THE SEDUCTIVENESS OF COMBINATIONS.

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Better words with which to open this paper can hardly be found than those of Dr. Thomas L. Shearer, in his address as retiring president before the National O. O. & L. Society last June. He urged the necessity of more exact prescribing and the more careful selection of drugs. In condemning the use of the compound triturate tablets put up by our pharmacies, he made an urgent appeal to physicians to take a decided stand against the prescribing of combination tablets. He said: "Truly, they are well named, for by their use we develop carelessness in prescribing, allow the selection of a remedy according to the law of similars to become a lost art, and remove the safeguards and defenses of our school—a combination of evils much to be desired by our enemies." And yet in spite of their evils, many physicians are led to use combination remedies because it is so easy. It often requires patience and long labor to differentiate between two drugs, either of which seems to be indicated in a certain condition. It is a remarkably attractive temptation to give both remedies and allow nature to select the one which is needed. The pharmacies are making this practice easy. Scarcely a week passes that does not bring me, either a sample bottle of tablets or fluid or large wads of literature, booming some particularly marvelous combination of remedial agents, warranted to cure some trouble hitherto considered unmanageable. Only the other day an agent called upon me and opened a satchel as large as an obstetric bag, filled with combination tablets.

The use of this means of giving medicine offers special inducements to the quack and the charlatan. It is only necessary to have an attractive office, a stock of combination tablets and specifics, and one is ready for anything. Even the labels, in some instances, do not tell what the ingredients are. Only learn the name of the trouble to be treated, find the bottle bearing the same name, and presto! the deed is done. Surely a seductive way of prescribing! But, alas, that the homœopathic physician, who has such a complete armamentarium, should fall into such lax habits.

It is certainly much easier to give a migraine tablet for headache, than to look up the similimum. But if the right drug be found, and that alone given, the good effects are not only more lasting, but are just as speedy; and the prescriber has valuable knowledge added to his experience. This was impressed upon me one evening when I met a lady with a terrific right-sided migraine. It was just the sort of case to tempt the use of a headache tablet. She was a visitor. I should probably never see her again; certainly not in a professional way. But fortunately there were no tablets convenient. So san-

guinaria was prepared and ordered to be taken every fifteen minutes until relief came. The pain was gone in twenty minutes.

A case of tonsillitis once brought to my notice an amateur use of combinations. The little daughter of a family had a bad sore throat and developed a temperature of 103°. Her father had dabbled some in homœopathy and attempted to break the fever. In the morning he came to me and said he was not able to do it. He had given a dose that should have knocked the attack higher than a kite, if combinations of good remedies were effectual. A homœopath had once told him that it was all right to give a number of drugs together, provided they did not antidote one another. So he had taken half a glass of water and put in a few drops of aconite, belladonna, phytolacca, and the protoiodid of mercury. I did not know of this remarkable prescription when belladonna alone was left to be taken, but the next evening the case was dismissed, practically cured.

Suppose this case had gotten well while taking the combination dose. What would have been gained? But the treatment with one drug gave the physician a renewed faith in the efficacy of the single remedy, impressed the family with the value of homœopathy, and "obliterated the disease in its entire extent, in the shortest, most reliable and safest manner."

Another case that strengthened the faith, happened early in my professional career. I was called in by a friend to treat his only son. The family had always been believers in the so-called "Regular" school and the gentleman's brother is a prominent specialist in the old school. When a few drops of the indicated remedy were put into a half glass of water, my friend picked up the glass, looked at it, held it up to the light and even smelled of it. It sorely tested all the confidence he had in me as a man to have his only child depend for his cure upon an hourly dose of a teaspoonful of apparently clear water. The case tempted the use of palliative or combination methods, for the gentleman was influential in the community and I was just starting in practice and naturally anxious to make a good impression. But homœopathy alone triumphed; for it is hardly possible that the boy could have made a more rapid or complete recovery under any method of treatment.

Those tempted to try easy methods of cure and use this seductive combination tablet, should remember that success is obtained only through work. And nowhere is work more richly rewarded than in homœopathy. It pays to search the materia medica. Our well known physicians are those who are most successful in picking the similimum. And while some may depart from the straight path and use other methods later in life, in most cases they keep their practice only because they are banking upon the reputation made in their early days.

In concluding we cannot do better than look at the words of the great father of homœopathy. Hahnemann says: "In the treatment of disease only one simple medicinal substance should be used at a time. Perfectly simple, unmixed, and single remedies afford the physician all the advantages he could possibly desire. And in obedience to the wise maxim that 'it is useless to apply a multiplicity of means, where simplicity will accomplish the end,' he will never think of giving more than one simple medicine at a time. It is certain that a simple medicine, well selected, will by itself be quite sufficient to give relief in diseases whereof the totality of symptoms is accurately known." Organon: Sect's 272, 274.



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## RE-PROVINGS OF THE HOMŒOPATHIC MATERIA MEDICA SHOULD REPRESENT ARTIFICIAL DISEASE.

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If any one thing more than another has prevented the acceptance and adoption of homœopathic principles throughout the world, that one thing has been a defective construction and improper classification of the records of drug provings.

It is a well-recognized fact that the present arrangement of the homœopathic materia medica, by individual symptoms, organs and regions, is such as to make the selection of the appropriate remedy a matter of laborious and often fruitless effort.

In an article published nearly twenty years ago, in the *New York Medical Times* of December, 1882, the writer, in calling attention to this important subject, presented substantially the following argument:

"It is evident that the plan of classifying the records of provings by organs and regions, inaugurated upwards of one hundred years ago, and followed without essential change to the present time, is extremely faulty, and is therefore susceptible of decided improvement.

"In his efforts to shun the old school error of prescribing for and treating diseases by name, Hahnemann ran into the opposite extreme, that of treating symptoms mainly.

"The prominence which Hahnemann gave to symptomatology no doubt prompted him to classify provings under the head of the organs of the body, an arrangement the direct tendency of which was that of defeating the accomplishment of the purpose intended.

"The segregation of the symptoms and classification of them under the several organs, breaks up and greatly obscures the natural evidences of the artificial disease represented by the proving.

"The proving, in its totality, or in its several groupings, represents artificial morbid conditions, which should correspond to, and constitute a counterpart of some form of actual disease; one occurring

spontaneously, so to speak, as met with in practice; the other, represented by the proving, as an artificial creation.

"The construction of these artificial diseases, through the instrumentality of the provings in their totality or in natural groupings of symptoms, should, as nearly as possible, faithfully represent actual diseases, yet should be so arranged as to be clearly distinguishable one from another in order to be made readily and accurately available in practice.

"When we listen to a recital of symptoms from which a patient is suffering, in spite of any effort to the contrary, the physician instinctively attaches to them a specific name.

"In like manner, when results of provings are being arranged for use, in order to be made homœopathically available, the records of such provings should be so constructed in groups or as a whole as to represent, as nearly as may be, a portrait of some particular condition of disease met with in practice.

"That is to say, the natural disease artificially produced by the drug being proved should bear the name of some form of natural disease occurring spontaneously.

"As a result of the adoption of such a system, we would have, in the proving, for example, the belladonna brain fever; the belladonna scarlet fever; the belladonna pharyngitis; also, the phosphorus pneumonia; the antimony pneumonia; the bryonia pneumonia, etc.

"These groupings of conditions would be represented in our textbooks, not by individual symptoms of the several organs, but by the totality of the symptoms so arranged as to present, as a whole, the particular physiognomy of the diseases for which each is homœopathic.

"The plan of breaking up the provings so as to represent only or mainly individual symptoms by organs often places in remote classes symptoms which nature has grouped together, thereby largely annulling the evidence growing out of association, natural grouping, and close relationship which are essential to the successful application of the law of similars.

"Such a faulty arrangement disintegrates that which nature has placed in juxtaposition, and even thereafter enables us to see only fragments of a harmonious whole, which, in order to secure completeness, reliability, and scientific precision, should have been preserved intact."

It is evident that this subject has been of late receiving increased attention, and that more significance is being attached to it than ever before, the trend of thought plainly moving apace along the lines herein described.

This fact is made particularly noticeable in connection with the present movement for reconstructing, on a modern foundation, the entire homœopathic materia medica.

Dr. H. P. Bellows, of Boston, Mass., who is at the head of this movement, in a recent address before the American Ophthalmological Society, in June, 1900, called special attention to the importance of recording provings in such a manner as to show natural relationships by an intelligent and accurate grouping of sets of symptoms that properly belong together.



He also enumerates, among the things to be attained by such re-provings, "a restoration of the natural sequence or grouping of drug effects, as indicated in different organs and tissues of the body."

He also further states: "And, above all, it seems like a golden opportunity lost if the sequence and correlation, or the distinct grouping of symptoms throughout the system, should not be studied and recorded.

"The disjunction of symptoms has been one of the most vital defects in the formation and study of our materia medica in the past, and the re-proving of drugs solely with a view to their effect upon individual organs or distinct biological spheres rather increases than corrects this defect."

He also illustrates this ideal method of showing that in the examination of a patient competency, experience and technical skill, on the part of the physician, are required in order to obtain a "true picture of the disease" from which such patient may be suffering.

In like manner, it may be argued, the same degree of competency, experience and technical skill is required in order to enable the prover to make records of provings that shall represent, by natural grouping of symptoms, a true picture of disease.

Both forms of physical disturbance being natural manifestations, there ought to be little difficulty in constructing, when these proposed re-provings are made up, a series of artificial diseases.

It is a source of gratification, therefore, to know that in the proposed reconstruction of the materia medica the final summary of the proving of each drug will represent artificial diseases rather than disjointed records of individual symptoms.

Let it not be supposed that these criticisms are intended in any manner to disparage the good work that is being accomplished under the successful application of the materia medica in its present form.

The materia medica now in use constitutes the very foundation on which, for more than a century, the principles of the homœopathic law of cure have been made practically available in every land.

The great achievements in the domain of homœopathic practice have been made in spite of the defects pointed out; a fact which shows, with special emphasis, the truthfulness and enduring features of the homœopathic law of cure.

At the same time, it is not unreasonable to assume that when this important work is completed and properly tabulated there will be provided an improved method by which any given series of symptoms and conditions can be more readily compared and studied; and the selection of the appropriate homœopathic remedy can be made with greater ease and accuracy.

# REPORT

OF THE

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

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"Relation of Lymphoid Hypertrophy to the General System," by F. PARK LEWIS.
"Catarrhal Preventives," by - - - - - FRED. D. LEWIS.

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## THE RELATION OF LYMPHOID HYPERTROPHY TO THE GENERAL SYSTEM.

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By adenoids we understand a hypertrophied condition of the lymphoid tissues, normally found in the vault of the pharynx, posterior to the nasal openings. In structure these tissues form a portion of what is known as the tonsillar ring, composed of the faucial tonsils on either side, the lingual tonsils, consisting of a number of enlargements at the base of the tongue, and the pharyngeal tonsil in the vault of the pharynx.

In a normal condition this last, the pharyngeal, or, as it is sometimes called, Luschka's tonsil, consists of a number of lymph follicles in the mucous membrane, surrounded by connective tissue. There is a soft variety of what is still called adenoids, which is simply an enlargement of this mucous tissue; the enlargement and hardening of the connective tissue is quite another thing. It has been deplored that either should be called adenoids, for not even the latter, or true adenoid, is a hypertrophy of the lymph gland. Practically it might almost as well be, however, for the contraction and hardening of the surrounding tissue cuts off the lymph flow as completely as if it were the lymph vessels themselves that were affected.

It must be remembered that the lymphatic tract is the channel through which the nutritive elements of the blood are carried to their destination. The lymph in the human body is its life. It is



the food of the cell. Upon its free flow is dependent the functional activity and the normal development of every tissue.

The lymphatic glands in the vault of the pharynx are part of a chain extending through the openings of the skull, carrying nutrition directly to the brain itself. Immediately above this region is the sella turcica, which contains the pituitary body. Those of you who have been following modern medical research, will remember that in the strange and interesting condition called acromegalia, or giantism, in which abnormal enlargement of the whole bony structure occurs, post-mortem investigations have discovered an enlargement of this pituitary body as a most constant feature.

The pituitary body is composed of two lobes, one of which is true brain tissue, and the other a lymphatic gland. The chain is continuous from the lymphoid tissue in the vault of the pharynx to the substance of this gland itself.

Now, when we realize how profound is the disturbance of nutrition throughout the entire system when the functions of the pituitary body are disturbed, it may be readily understood that any obstruction to the free flow of lymph through glands so nearly adjacent as those of the pharynx, might seriously interfere in other ways with the processes of development.

A disturbance of function always precedes a change of structure; and if it can be shown that functional disturbances are produced in adjacent organs by hypertrophies of the lymphoid tissues in the pharynx and the post-nasal space, the conclusion is justified that in case the hypertrophies are allowed to continue, structural changes must follow.

Should these hypertrophies occur during the period of development in children we are warranted in making the tentative deduction that where functional disturbances have been observed, interference with development is likely to occur, as structural changes would in an adult.

Now, clinically, the relationships between adenoids and deformities of the face, nose and chest, have been so constantly observed that the facial appearance has come to be accepted as a characteristic indication of the presence of adenoid vegetations in the naso-pharynx.

Their relationship to some forms of ear disease, while often recognized, has not yet received the attention which its importance demands, while the connection of hypertrophies of this nature with the eye, and its development, has scarcely received any consideration whatsoever. Indeed, I cannot find that this aspect of the subject has been studied at all.

The typical adenoid face is well known. The enlargement of tissue obstructing the posterior nares so narrows the calibre of these openings that breathing is possible only with the mouth partially open. The upper lip is commonly shortened, the lower lip drops. This not only gives a stupid expression to the face, but the mental processes are actually slow. The child finds difficulty in concentrating the attention on any subject and reflex symptoms of the most varied character are not uncommon. (Among these may be men-

tioned the night terrors from which children suffer, wetting the bed, persistent headaches, not relieved by ordinary measures, marked catarrhal symptoms, and the like.

The form of skull which is found so commonly in cases of this character is that in which the upper jaw—sometimes, indeed, the lower as well—is narrowed laterally. The face is compressed from side to side, and the bony palate forms a high arch. The teeth are so crowded that they find no room for regular eruption, and to the unpleasant, rat-shaped face is added, therefore, the disfigurement of an ill-shaped mouth with irregular teeth. The high arch constituting the bones of the roof of the mouth presses up the septum of the nose, causing it to deviate, and laying the foundation for future obstructions in the nostril.

In a word, the mechanical fact of crowding the face together throws all the bony structures out of their true relationships and is the foundation of disturbances of a most serious character.

Much thought has been given to the manner in which this peculiar conformation occurs, and the conclusion seems to have been that the obstruction of the nose by the adenoids, necessitating mouth breathing, has gradually drawn up the, as yet, plastic structure of the roof of the mouth, until this conformation has resulted. That this is not a complete explanation, although it may be a contributing element, is shown by two facts; first, that the condition is sometimes present at so early an age that it could not have been produced by suction, as this process would necessitate time, and the condition must have been congenital,* and, secondly, because it has been exhibited in branches of families to such an extent that the element of heredity must enter largely into it.

A case that came under my observation recently was that of twin children, in one of whom this facial contortion was conspicuous, while in the other the face was broad and the jaws roomy. The first child was a mouth-breather from birth. The mother assured me that this child was the elder and had been carried low in the pelvis, leading to the possible inference that the weight of the other child, by continued pressure, might have changed the shape of the skull.

The facial conformation characteristic of this condition frequently is found in a mother and her whole family of children.

It would be interesting to know whether a narrow pelvis might not sometimes be instrumental in producing the narrow head, which is the foundation of the whole condition. But while all this affords a fascinating field for speculation and theory, it is not essential that we should know how it is produced; it is sufficient to realize that a condition which will so crowd the jaws that the teeth have not sufficient room for their eruption, may also so impinge upon the lymph channels as to produce strangulation of these structures with subsequent hypernutrition and the abnormal development of connective tissues, which we call adenoids.

*Chaureau operated on over fifty newborn infants. Vide *Gaz. Lebdom. de Med. et de Clin.*, April 8, 1900.



Therefore, although the consensus of opinion seems to have been that suctional breathing, the result of adenoids, has been the cause of the narrowed face and head with all the attendant symptoms which we have been considering, I cannot but believe it more probable that the reverse is the fact. That the narrow head and face, having been produced by any means whatsoever, would naturally result in obstruction of lymph passages, with all the varied and unfortunate phenomena which such obstruction implies. (I should say in parenthesis, that the narrow face with its attendant obstructions is not the only thing that could crowd upon the delicate developing tissues until adenoid growths result. But cases where abnormalities of the face are not present would be the concern of the general physician, not of the dental surgeon, and therefore will not be considered in this paper.) If my theory is correct, its importance to the dental profession is obvious.

By an early expansion of the jaw, not only is the unpleasant rat-mouth molded into better form and the teeth given room to develop properly, the bony arch lowered, and the lips thus brought into place, the nasal septum straightened and the features given a dignity, and the mouth an efficiency, that they would otherwise lack, but the lymph channels are unstopped. The first of these are chiefly mechanical results, the latter is concerned with the essential elements of structural nutrition.

The different organs that may be affected when nutrition is interfered with, and the various ways in which deviations from the normal occur, interest chiefly, of course, the general physician. But the whole subject, even pushed to somewhat wearisome detail, is of importance to the dental surgeon as it urges upon him the necessity of recognizing the less striking cases of this formation. Then, when recognized, in instances where the facial deformities are not extreme, or but slightly apparent, there is sometimes difficulty in persuading the parents to submit children to surgical interference, which the dentist must insist upon. The process is a long and expensive one, and entails not a little discomfort, and the parent is likely to urge postponement, hoping that the necessity for the operation may disappear with growth. A knowledge of the remote and serious difficulties which may be the outcome of this condition will afford the surgeon, in the several details, many weapons for the defense of his position.

One of the most obvious effects of adenoid obstructions in the vault of the pharynx is the mechanical interference with the ventilation of the middle-ear through the eustachian tubes. According to the location of the adenoid growths, either one or both sides may be involved. The necessity of an unimpeded passage through the nose, as related to the ear, may be immediately demonstrated, in a normal condition, by the simple experiment of closing the nostrils. This may be made more clear by (at the same time) trying to swallow. We find this same process emphasized by a common cold in the head, which gives the sensation known as a stuffy feeling in the head and ears.

Now with enlarged tissues in the throat it requires a very slight inflammation to so interfere with the mouths of the eustachian tubes as to almost completely shut off the entrance of air. The continuity of tissue readily allows an extension of the inflammation to the middle-ear; the drum membrane also becomes inflamed. The swollen tissues of the tympanum ultimately fill with pus and the pain is excruciating until the membrane is ruptured, or an opening artificially made by the surgeon's knife, and we have all the classic symptoms of otitis, with the possible resultant conditions of a chronic otorrhea, mastoid involvement, cerebral abscess, sinus thrombosis, or even general septicemia. I think it rarely happens when children have repeated attacks of earache, that investigation will not show the presence of adenoids.

The continued obstruction of the eustachian tubes without inflammatory complications develops a progressive form of catarrhal deafness, for which no relief can be obtained as long as the obstructions continue.

This is a kind of chronic deafness, the origin of which is frequently overlooked. In the course of time organic changes occur in the structures of the middle-ear, such as retraction and thickening of the drum membrane, adhesions at the joints of the ossiculæ, and in some cases, involvements of the nervous structures of the inner ear itself, with permanent narrowing of the eustachian tube. It is, of course, then too late for the removal of the cause to produce beneficial results. With a knowledge of these facts it is obvious that no case of deafness in a child should ever be allowed to continue without a thorough examination of the throat, to determine whether obstructions are present or not.

The large number of deaf mutes in whom adenoid vegetations are found to exist would seem to justify the conclusion that these obstructions were either congenital or pre-natal, and that deafness being present at so early a period allowed the unused ear structures to degenerate, while the brain center for audition remained undeveloped.

The remarkable experiments of Urbanschitsch in the training of mutes with ear trumpets, would indicate that in many of these cases some degree of hearing might be secured by training the ear, if the auditory passages are free from obstructions.

Of course, it is only before structural changes have taken place that beneficial results may be anticipated.

Structural changes take place in a comparatively short time, when, added to disuse, we have a choking of the channels of nutrition. The presence of adenoids in the throat may, therefore, be responsible for structural changes in the ear, and not many years be required in the process. This makes evident the necessity for careful diagnosis and prompt care of young children when these conditions exist.

It is an accepted idea that adenoids left to themselves will atrophy at adolescence, but this is only partially true. The growth may, and probably does, shrink somewhat, but when connective tissue changes have once occurred, the adenoid persists, although the enlargement



of the vault of the pharynx coincident with normal growth lifts the enlarged tissue so that it no longer obviously obstructs the nares, and while it may be producing disastrous changes its presence is often totally unsuspected.

I have myself removed large adenoids from a man thirty-five years of age, very greatly relieving his deafness in one ear. In the other tissue changes had occurred to such a degree that improvement of hearing was impossible.

It is the persistence of these unrecognized progressive tissue changes that lays the foundation for much of the incurable deafness of adult life. And when these are the result of abnormal growths which may in turn be the result of abnormal mouth development, not only must the growths be removed, but the care of the jaws and teeth must not be too long postponed.

Now I have reason to believe that the obstruction of the flow of lymph carrying nutrient elements to the ear, has possibly as much to do with the results as the mechanical obstructions, shutting off the eustachian tubes. But upon this subject the final word has by no means yet been said. When we speak of the eye, the dental relationship would seem to be less apparent, but as a matter of fact we find here similar conditions, giving rise to equally marked results.

And if my theory is correct, that distorted facial development produces adenoidal growths, and that adenoids are responsible for various eye troubles not hitherto traceable to any direct cause, the relationship is discovered to be intimate.

If, as was shown in regard to the ear, functional difficulties arise in conjunction with adenoids and disappear on their removal, and we remember that structural changes invariably follow a persistent aberration of function, we may say that here, too, similar conclusions follow like premises. That is to say, structural changes in the eye may occur as the result of lymphoid hypertrophies. And, furthermore, if these obstructions to normal nutrition occur during the plastic period before development is complete, they may interfere with the normal growth of the organ, and arrested development be the result.

No one, two, or three cases would be sufficient to prove the relationships of adenoids to disturbances of the eyes, but when over and over again cases that have evaded all ordinary medical or surgical measures have been immediately relieved by the removal of lymphoid growths, the causative relationship would seem to be demonstrated.

One of the commonest conditions which I have observed in this connection is that in which the conjunctiva is congested, the eyes weak and suffused, a condition for which local measures have proved in many instances totally insufficient, but which was at once relieved by the discovery and removal of adenoids.†

A peculiarly interesting case came under my observation recently of a child having a persistent overflow of tears from one eye. The

†Coppez and Snellen have reported cases of follicular conjunctivitis cured by the removal of adenoids. Vide *Arch. d'Ophthal.*, January, 1899.

lachrymal duct was found perfectly normal, and the overflow, which had for several years resisted treatment, ceased within a week after the removal of a small mass of adenoids that had been too slight to occasion the child any other discomfort.

Various weaknesses of the ocular muscles, for which suitable glasses and even operative measures have been unavailing, have regained their normal balance after the naso-pharynx has been cleared.

Lauren's case, in which strabismus disappeared after an operation for adenoids, and Miles's cases of asthenopia, which subsided after similar operations, lead directly, as do all of these cases, to a consideration of the development of the eye and the causes which may modify it.

Now, at birth, the eye of a child is in the same undeveloped condition as are the other organs. As the child grows the eye develops, enlarges, and becomes functionally able to do the work which is required of it. This process of development extends, normally, through the growing period of the child's life. If, for any reason, it should be interrupted, the eye remains, throughout life, that of the child. It is then too flat, never having reached a full contour, and is called a hypermetrophied, or over-sighted eye. Such eyes are peculiarly prone to convergence and are apt to be dull-sighted.

Ziem‡ has recently made some very interesting experiments, that are most suggestive in this connection. He sewed up the nostrils of young rabbits and found that on the side from which air was excluded, the eye remained in a permanently undeveloped condition. In other words, it remained a flat or hypermetropic eye, while that on the opposite side reached its normal development.

Now in my own experience, such a large number of these hypermetropic and squinting eyes in children, up to about twelve years of age, have been found in connection with lymphoid hypertrophies, that it is impossible to believe the association accidental.

If it be true that the nutritive functions of the head are so profoundly impaired by naso-pharyngeal hypertrophies, and if it be also true that these are again contingent upon corrigible deformities of the skull, I can only say again, if possible with still more emphasis, that as the responsibility in this class of cases often falls upon the general practitioner, long before any developments occur which would bring them to the care of the surgeon, the entire subject must be regarded as of an importance which can hardly be exaggerated.

DR. LEWIS made the following additional comment in the course of the foregoing paper:

I have a number of casts which illustrate this in a very interesting way. I have brought a few out of a very large number that I have had taken from time to time in which that contour of mouth, with the irregularities of the teeth, is very pronounced. (Showing specimen.)

This is another very marked case (indicating) in which the incisor is found practically in the roof of the mouth. That (indicating

‡*Monatschrift für Ohrenheilkunde*, Vol. 31, No. 12.



another) is peculiarly interesting as showing a bit of bad dentistry. The extra teeth were extracted at a period in the boy's history when, had they been retained, and orthodontia secured, by having the jaw expanded, it would have preserved the natural contour of the face and given the boy his full complement of teeth; and, as you will see, if I am right in my premises, would have greatly improved the boy's general condition.

This (indicating another specimen) shows to a very marked degree the enormously high palate. In a case of that kind it is difficult to see the roof of the mouth by looking underneath, the boy's palate is so high. It is only when his head is thrown back and light is thrown in that you can see it, and it is just barely possible for me to get my finger in the narrow arch, it is so high and so very narrow.

This illustrates the same thing (indicating another). I have taken these from dozens that I have had taken during the past few years.

Practically, what occurs is just this. If the sides of the face, when the parts are in a plastic condition, when the bones are easily disturbed, are simply squeezed together, we get exactly that contour of mouth and the deformity of face that we find in these children. The roof of the mouth is pressed up; the jaws are so narrowed that the teeth have no room for their proper irruption. They, therefore, come out in front and back of the normal row. The septum of the nose, by the upward pressure of the bony palate, is bent, and we have then laid the foundation of all the disturbances of the nose that we find in after life, together with the deformity of the face to which I have called attention.

Coppez, in one of the French journals, reports that he has operated on fifty cases of children a few days after birth, which is conclusive in demonstration of the fact that we are dealing with a condition which is congenital. I have seen cases of the kind myself.

I have frequently noted that the line of heredity seems to be through the mother, that the male children take the contour of face of the mother in those instances, and that leads me to the possible surmise that the narrowed head accompanies sometimes the narrow pelvis, that the conformation of the mother's pelvis might give rise to this narrow shaped head.

A writer to whom I refer in one of my foot notes, found, in thirty-eight fatal cases of diphtheria, twenty in which adenoids were not present. It has been my experience for a long time that those cases of scarlet fever and measles which result in otitis, are those cases in which adenoids are present in the throat; so that when we get the additional inflammation in the throat brought on by any of our eruptive diseases, we have a condition so predisposing to an extension of the inflammation to the middle ear that it is almost impossible to avoid it. Of course, the inevitable conclusion is, the wisdom of removing those obstructions before inflammatory diseases of the throat come.

I have here a mass of this tissue that was removed by my friend, Dr. Hoyt, from a patient under my care, and the hard connective tissue substance can obviously never absorb; never could, under any

circumstances, so far as I can understand, disappear by atrophy. That has been in formalin for some months. It certainly is a fact that in a very large number of cases these things do not disappear. They simply go out of sight and out of reach so that they are not recognized.

This little growth, not bigger than that, (indicating specimen) I took from a child last Saturday, following follicular inflammation of the conjunctiva of one eye. On Monday (yesterday) the eye was already greatly relieved. I have seen this occur a number of times, and in the note which I append to my paper there is mention of some other observers having noted the same fact in a large number of cases.

DR. MOFFAT: Follicular conjunctivitis?

DR. LEWIS: Follicular conjunctivitis.

## DISCUSSION.

DR. MOFFAT: Specialists are too apt to think that their specialty is the root of the trouble; it is entirely illogical for the laryngologist who discovers adenoids, who has made it a point of removing them, to think that they will necessarily be the cause of the bony changes. Dr. Lewis has made a very important suggestion and one that we have not heard the last of. Otitic grippe is probably in many cases determined to be otitic by adenoids. It is an old story with us all; it we see a case of very large tonsils and adenoids, we are afraid of diphtheria in that child. In one or two of my cases of otitic grippe, in fact, I think every case, I can recollect having seen large tonsils, although I would not want to state that decidedly; it is only from memory.

DR. NICKELSON: I would like to ask Dr. Lewis if the use of the forceps in delivery would not cause the same deformity of the head as the contracted pelvis.

DR. LEWIS: I had already extended my paper very much beyond the limits which such a paper ought to cover, but had it permitted I would have been very glad to go into the deformities produced by forceps deliveries. I have seen during the last number of years a very large number of interesting nervous involvements. Oliver has recently written a paper for the *Journal of the American Medical Association* which covers this ground in a measure, but the whole subject is a very broad one, and one which could with advantage occupy an entire meeting of a society. There is no question at all that the pressure produced in that way might result in just such disturbances as these.



## CATARRHAL PREVENTIVES.

FRED D. LEWIS, M. D.,
BUFFALO.

"An ounce of prevention is worth a pound of cure." How true is the old adage, and yet how generally neglected. At a meeting of this Society two years ago, I presented a paper on sprays, and my opinion as to the habitual use of a spray, particularly in city life, as one of the preventive measures, not only remains unchanged, but has been strengthened. However, it is not my intention now to review my former paper, but to supplement it. I remember distinctly a remark made by one of the professors to my class, when I was attending college: "The best way to avoid disease is to keep healthy." This, of course, holds good in reference to any disease, for if one were in perfect health, he could come in contact with any contagious condition without contracting it. However, there are special precautions to be taken in the avoidance of acute rhinitis, or as it is commonly termed, "taking cold." Now, we must understand from the beginning that nasal catarrh is nothing more than a chronic rhinitis, induced by repeated acute attacks. Therefore, the subject now to be considered is how to avoid taking cold.

First, then, for us to understand are the conditions under which a cold may be established. The most frequent cause is the rapid abstraction of heat from a limited surface of the body. One may be exposed to a strong wind in the open and not be affected thereby, but let the same air come as a draught from a partially opened window or a broken light of glass, and blow on the back of his neck, and a cold will result. How, then, shall we overcome this effect? The most valuable means, in my opinion, is the regularly taking of a sponge bath each morning, followed by brisk friction. I think it is not essential that the water be cold, the hard rubbing after being the most important part. This acts for the good of the patient in a two-fold manner. First, it stimulates a good blood supply to the surface, and renders the skin more elastic, so the pores may more readily close on a sudden reduction of temperature to the part; and second, we all know the important part the skin plays in the elimination of the waste products of the body, and if kept active, relieves the bowels, kidneys and lungs of a great amount of work.

The next point to consider is that of dress. I believe that there are more bad results from the effect of over-dressing than occur from under-dressing. When the cold weather comes, it is customary to get into heavy flannels, increase the weight of the outer garments, and then put on a heavy overcoat before going out. Now, as our homes are kept at very little below summer heat in the winter, the clothing should be only slightly heavier than we use for summer, and the protection from the cold added on going into the outer air. A great mistake and the one that is productive of the greatest number of attacks of acute rhinitis, in my opinion, is the lack of

care in protecting the feet. The shoes that are worn, and particularly by women, have thin soles. These are worn about the house, walking on warm carpets, and the change to cold sidewalks is quickly felt. Most people put on rubbers when the streets are wet, but seldom protect the feet from the cold stones. It is not necessary to wear rubbers during dry weather, but a pair of insoles might then be used. One pair of insoles, in my opinion, being worth more as a protector than all the chest protectors ever made.

I might enter here into the diet, which I think is of extreme importance, as excessive eating or drinking, or the use of improper food or at unusual hours, may be responsible for frequent attacks of rhinitis, or I might speak of the hours of rest, and kind and amount of exercise to insure the best health, but these subjects have received so much attention for the last few years that they are familiar to all.

This whole paper sets forth no new ideas or suggestions, but I excuse myself for its presentation only on the grounds that it is often profitable to review a subject, and to impress in the minds of all that an ordinary cold is too often considered as only a cold and will wear off in a few days, when in fact, it is a manifestation that something is wrong either in the constitution of the subject or his surroundings, and nature is crying out for its correction.

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## DISCUSSION.

H. D. SCHENCK: I think Dr. Lewis mentioned sponge baths as one of the preventives to taking cold. I would like to call the attention of members to a little modification of that in cases where the cold bath, followed by friction, does not prevent the recurrent attacks of rhinitis or pharyngitis; viz., by first bathing one arm with hot water, and then with extremely cold water, and following in the same way with the other arm, then the body and finally the limbs. The shock and the rubbing afterward until the body is thoroughly warm and the blood drawn to the surface will often prevent constant colds where the cold bathing alone will not. I hardly agree with Dr. Lewis in the statement that it makes no difference how cold the water is. Water at a temperature of fifty-five or lower is much more beneficial, if followed by thorough friction of the skin, than at a higher temperature. Dr. Houghton, of New York, presented the suggestion of alternating cold and hot bathing to this Society some years ago.

DR. PALMER: Having only received the copy of this article yesterday afternoon I have had but little time to think it over. But as our attention at present is given as much, if not more, to the prevention than the cure of disease, it is most timely and instructive. Little can I add to this; but two points I wish to emphasize: One is that there are very few of the laity, and even of the physicians, I might say, that consider the taking of a cold in the head so important a condition as it really is. They do not consider it as a real disease. Even the busy practitioner seldom thinks of it as such. If it were



not for the idea that this cold in the head would wear itself out in a few days, the specialist would not have so many conditions to operate upon as he does. This cold in the head, or, rather, the repeated conditions, cause the hypertrophies that are so deleterious, and also cause the chronic catarrhal condition that the doctor speaks of. It also predisposes to ozœna, or fœtid catarrh, either that from trophic changes in the nose itself or that consequent upon sinusitis. Another point that I thought needed greater emphasis was with relation to overheating, or dressing too warmly. That, as the doctor says, opens the pores. It causes a greater amount of perspiration. A person that uses the heavy underwear also employs heavier outside garments when he goes out, and the condition is this: that we are in the summer atmosphere of the house usually about four-fifths of the day. During this time under this superheated and dampened atmosphere under the clothing the sudoriferous glands are overstimulated, get into an abnormal, chronic, active condition. The excess of perspiration thus excreted is evaporated by any temporary lowering of temperature; this, of course, chills the subjacent surface and the more frequently brings about the condition termed "taking cold." One point worthy of note which I think the doctor omitted is the prevailing idea of ventilating bedrooms while the occupants are asleep. What are the conditions of the human system which pertain at this time? During the night the nervous system is at its lowest physical ebb, shown by the lower bodily temperature during the night and in the nares the venous tissue of the turbinated bodies is normally engorged on account of the recumbent position of the body, therefore more susceptible to the lowered temperature. On this account it seems more judicious to ventilate the bedroom principally during the day time.

F. PARK LEWIS: I am sure I have cured a number of cases of sensitive throats by simply making women do away with their furs. There is no other one thing that does so much to produce a sensitive, catarrhal throat as to keep it overheated; and the mere fact of taking from the throat the fur that women wear, and gradually exposing the throat to the temperature until it becomes as tough as the face, and as well able to endure changes of the weather as the face is able to endure it, will in a very large number of cases do away entirely with the sensitiveness of the throat. I have seen it practically worked out in a very large number of cases.

DR. MOFFAT: I want to remind the members present of what they already know, that it is change of temperature that gives the cold, and we have all been in many a house where the family have very warm living rooms and very cold halls, and yet they are surprised that they should catch cold. They catch cold indoors more than they do by going out of doors. Another great cause of catching cold is the habit that women have now-a-days of wearing low shoes in winter with thin soles; we can talk till we are deaf and dumb and blind, but I don't believe we will stop them. (Laughter.) Another point that I have been talking with a great deal of success when the patients have minded me, is against this habit among young and old women of wearing the stiff, high collar. They seem to think that

because we can see a little space between the skin and collar that the collar is not doing them any harm. I have in mind one high-school girl who stopped her headaches and got her lessons with comparative ease after I had succeeded in making her discard that high collar—the high collar, the stiff collar, the stock. I need not remind you all that it is the pressure of the lower edge of the collar upon the superficial circulation by the chin when they are reading and studying that is probably doing most of the harm. I ask them if they have as scrofulous necks as Queen Alexandria, who started the fashion. (Laughter.)

DR. ZWETSCH: I believe there is everything in keeping the feet warm. As a boy I was troubled with catarrh. I had catarrh until I commenced to study medicine. I have always made it a practice to keep my feet warm. I have never done anything further for it. I have not been sick in bed a day in twenty years. I think my wife does the same thing. I believe the most important thing is to keep the feet warm and dry, and that that will prevent more diseases than anything else in that direction.

F. PARK LEWIS: And wearing a low collar. (Laughter.)

DR. ZWETSCH: And wearing a low collar. That, I believe, is one of the most important things, keeping the feet warm and dry, in fighting colds, or rheumatism or anything else of that kind.

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# REPORT

OF THE

BUREAU OF PUBLIC HEALTH.

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## THE PUBLIC HEALTH—A SARCASM AND A SUGGESTION.

LYNN ARTHUR MARTIN, M. D.,
BINGHAMTON.

The excessive development of our philanthropic nature has been for centuries our most characteristic feature.

The physician is the personification of mercy, generosity and self-sacrifice. He always yields gracefully to whatever demands are made upon his time, purse or profession. And so, in time of need the public turns to us and takes our best and our all as its just portion. And no one says them nay. As a beggar once said to a doctor who upbraided him for calling so often, "Where should I go, but where I get things?" We are the buffer between the public, and disease, discomfort (mental and physical) and death.



The plague no longer decimates Europe; yellow fever has ceased to be the horror of the tropics; typhus is rare in its former haunts; scarlet fever and measles are tamed; diphtheria manageable; gangrene and puerperal fever almost unknown. For all of which we are duly grateful, and for which the profession deserves more than a vote of thanks.

But the doctor's income suffers in consequence. Small-pox is on a rampage at present, but not of its former destructive type. If, in the war of 1860 it took (3,000) three thousand bullets to kill a soldier, how many calls on malignant disease will it take to kill a doctor? The service of the soldier is unquestioned and he deserves his pension. But how about the bravery of the doctor, and his value to the country as a fighter for life and liberty? But is the doctor ever pensioned, or homes maintained to sustain him in his declining years, or when accident or disease lays violent hands upon him?

Charity should cover a multitude of indiscretions, but how can we better help others than to help ourselves? We must rise or fall together.

No intelligent merchant puts up a guard to stop business and curtail his income. Because we have always given, must we give in perpetuity? As business men we have become imbecile. The financial side of the public health needs "a list to starboard." The doctor's investment in public charities is out of all proportion to the returns.

The public dispensaries and hospitals for the insane, tuberculous, epileptic, crippled, blind, lying-in women and contagious diseases write us up in red ink at our bankers.

The man in town no longer needs a family physician. He reads "Science and Health" or "First Aid to the Injured" and goes to the dispensary 'round the corner, or calls a cab and goes to the hospital.

Philanthropy is the great cry of the age, and we can each do a little in some direction, but there are few of us who can compete with the steel trust or standard oil magnates.

While philanthropists are building libraries, hospitals and homes, what is the objection to a home for ancient and honorable physicians? The men who have made the charity hospital possible.

The joy of the practice of medicine lies in the ability to give and to do; to do nobly and to give generously. "He that giveth to the poor, lendeth to the Lord," but he that giveth to the "public health" impoverishes his family. Everything possible should be done at all times for the sick and suffering, but why, in all of our charitable institutions is there provision made for all expenses save those of medical attendant? Are our services of so little value? Are we of less consequence than the janitor?

What we need is more business (or its equivalent), not less, or else adopt the Chinese system of having the public pay for being kept well.

Some of these things may be said in jest, but if you are to live by the perspiration of your intellects, they will merit your serious consideration.

Give the doctor a chance, and in the words of a famous railroad president, "The public (health) be ———." (Applause.)

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## DISCUSSION.

DR. LESEUR: *Mr. Chairman*, the paper which Dr. Martin has just given us is refreshing for its originality and is characteristic of the writer. It is discreet in its position, it is singular in its expression of interest in the welfare of the physician. The public does seem to have acquired the opinion, whether justly or otherwise, that the average physician of to-day, through some peculiar combination of circumstances or peculiarity of education, has acquired the ability to take care of himself and that he does not need the provision that is made for some of those who, traveling along life's highway for a considerable time, become halt and lame and weary and unable to take care of themselves. I believe there is in the doctor's paper a grain of truth which merits the consideration of thoughtful physicians. I know of no reason why the law of this State should provide that the undertaker should be secured for the payment of his services when the patient for whom the physician has cared is beyond the reach of human help, and that the physician should have no means to secure pay for his services until after the undertaker has been paid. Of course where the estate is sufficient to pay all the debts of the late lamented there is no question raised, but if it comes to a question between the undertaker and the physician, the latter must go unpaid. The undertakers combined to secure the passage of a law protecting them. Is it possible for the physicians to do so? If possible, is it desirable?

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## VACCINATION, A PRIVILEGE OR A DUTY?

JOHN W. LE SEUR, M. D.,
BATAVIA.

If it be true that there is nothing new under the sun, it is also true that old facts occasionally present new and intensely interesting features.

Since the discovery of the use of vaccine virus, there has been



more or less continuous discussion as to the desirability and the efficacy of vaccination. From time to time as different countries have been threatened with an epidemic of small-pox, spasmodic efforts have been made to secure general vaccination. More or less success in this direction has been attained, but the experiences of skillful physicians have produced widely differing opinions as to the results attained, and the wisdom of endeavoring to secure universal vaccination. Statistics have been compiled by private individuals and by government authorities and have shown vast differences.

From time to time the question, to vaccinate or not to vaccinate, has engaged the attention of members of the medical profession everywhere, and health departments in the various States have found very puzzling questions presented, when they have endeavored to enforce general vaccination. The latest effort in our own State to throw the responsibility for the securing of general vaccination upon the school boards, has had varying degrees of success, according to the pliability of the various cities or towns where it has been ordered, or the persistency or obstinacy of the various families affected by the general order to vaccinate.

I should not feel justified in taking the time or asking the attention of this learned body of physicians at their annual meeting in this Empire State, if it were not true that the question of the wisdom of vaccination presents itself for our consideration as physicians with several new and important features.

It is doubtless true that more physicians in the Empire State to-day would favor vaccination than would be found to oppose it. It is by no means so certain that the present minority is not likely to be, if not indeed certain to be the majority in the near future, unless the conditions surrounding vaccination can be, first, thoroughly studied; next, thoroughly understood; then, properly controlled. It is true that what may be said of infectious and contagious diseases in general, may with equal force, be said of small-pox, viz.: There is vastly less virulence in contagious diseases now than there was twenty-five years ago. It is probably true that the death rate from all classes of contagious diseases is very much lower in the year 1901, than it was in the year 1801.

The enthusiastic advocates of vaccination will be inclined to claim that this diminution in death rate is due to the effects of the vaccine virus. But equally intelligent physicians, whose wide experience amply qualifies them to express an opinion, will reply that the improvement in sanitary conditions is as much to be credited with the lower death rate, if not more so, than the vaccination.

All types of contagious diseases being milder, the necessity for vaccination would seem to be somewhat lessened, if it were not true that from the mild type, frequently the severe form develops. In the larger cities in this country where sanitary appliances ought to be the best; where plumbing is under skilled official surveillance, where water supplies are carefully guarded; where sanitary regulations are intelligently framed and thoroughly enforced; where public baths are provided for the indigent and the illiterate; in these centers

of population and homes of intelligence within the last two years, there have been remarkable outbreaks of small-pox.

The city of Philadelphia, the city of Buffalo and the cities of New York, St. Louis and Boston have all during the last year had an unusual number of cases of small-pox. The classical, cultured, New England Metropolis of Boston, is at the present time struggling with one of the most severe epidemics of small-pox that she has ever known, and the struggle is becoming so serious a matter that the police department is now being called on to enforce general vaccination.

It would seem to the casual observer, be he physician or not, that the question to vaccinate or not to vaccinate, is likely to be food for thought for cultured Boston.

Whether the litigation that may result from enforcing vaccination shall decide the question for us, whether it is a duty or a privilege to be vaccinated, or not. If the question were asked of that body of active, progressive practitioners to-day, "Shall we vaccinate, or shall we not vaccinate?" no prophet in this body would attempt to foretell the answers of a majority of you.

From the moment that you began to listen to this paper your thought has been busy with the consideration of the serious results that have attended vaccination in some of the cities and towns of this and adjoining states, and every individual who inclines to oppose vaccination is ready with an argument to the effect that the possibility of the introduction of the germs of tetanus is a sufficient reason for the interdiction or prohibition of vaccination.

On the other hand some one will ask, "Is it fair to judge the general results of vaccination by the effects which have arisen from carelessness in the production of the vaccine virus used, or have followed as a result of carelessness upon the part of those vaccinated?"

The cases of tetanus in Camden, New Jersey, have doubtless aroused the interest and thought of practitioners all over this country, if not all over the world. These cases of tetanus have called attention to the fact that as a rule vaccinators are careless in the performance of this important work. Doubtless, most of you would agree to the proposition that vaccination should be undertaken with the same care, the same cleanliness and the same conditions of asepsis as an important surgical operation. But many of you will recall cases in which vaccination has been undertaken when most of the ordinary precautions for asepsis have been absent.

You will doubtless all agree that it is eminently desirable and perhaps not impossible, to secure either by legislation, or by the intelligent co-operation of health officers throughout the several states with the manufacturers or preparers of vaccine virus such general, scientific and honest supervision of the preparation of product as shall secure for the use of physicians a pure and efficient vaccine virus. You will perhaps agree with the writer in the opinion that something should be left to the judgment of the individual physician when general vaccination may seem desirable. That in cases where the



blood system is already infected or where the general vitality of the individual is much below par. In cases of persons of advanced years the physician should be allowed to exercise his own judgment in the individual case.

It is also a question in the minds of thinking men in the profession and among the laity, whether or not the State has a constitutional right to enforce vaccination. Whether the police power of the State can be carried so far as to compel Mr. A. to receive into his system a substance definitely known to be poisonous for the purpose of protecting himself from a danger which may be or may not seem to be to him a serious one. These are live and burning questions to-day, and questions which call for the best thought; the most careful consideration of physicians of all schools of practice.

A recent number of a prominent medical journal in our school, printed under the supervision and at the request of one of our most prominent physicians, a series of letters from practitioners in various parts of several states, answering the question, "Do you or do you not vaccinate?" The answers received to these questions were almost as varied as the personnel of the writers, but running through all the letters was a tinge of doubt as to the wisdom of vaccination under existing conditions. If it could be conclusively proved that vaccination in all cases prevented the spread of small-pox; if no person had been ever found who had contracted small-pox after having been vaccinated thoroughly; if no person had been found who had twice suffered from an attack of small-pox; if the rigid disinfection and quarantine maintained by intelligent boards of health always controlled the spread of small-pox, then there would be no question as to the desirability of vaccinating most persons. But, if vaccination sometimes causes lesions more serious than the small-pox alone would cause, and if, as some German authorities claim, vaccination does not always render individuals immune, then the interrogation point still must be placed after the word vaccination.

No satisfactory explanation seems to be given for the variation in virulence of small-pox epidemics in the same country separated by limited periods of time. Dr. J. F. Runyan calls attention of the medical profession in the *Philadelphia Medical Journal* of September 28th, 1900, to the fact that in two epidemics occurring in the same place near Guthrie, Kentucky, in the first one in the spring of 1900, several hundred had the disease and there were no deaths. However, the disease was undoubtedly genuine small-pox. And the second epidemic in the same vicinity in the spring of 1901, was attended by a mortality according to Dr. LeRoy, in *American Medicine*, September, 1901, of sixty per cent. Now, here is a community living under identical conditions, that one year suffers the inconvenience of a mild epidemic of small-pox, and in the same year the ravages of the same disease in its most frightful form. The fact wanting in this account, and the one which we should especially desire to have in forming our opinion as to the wisdom of vaccination is, "Was that part of the community which escaped the first attack thoroughly vaccinated, and when the second epidemic came, did any of those persons who had

been vaccinated suffer from an attack of small-pox, and if so what percentage of those vaccinated were attacked and what percentage of deaths occurred among those who were vaccinated?"

There is no doubt that a general discussion of this question will tend to clarify and simplify it, and cause such legislation and such general knowledge as will be most useful to us in combating this serious disease.

A question which perhaps we ought to consider at this time, is this: "Would it be wise for each of the three recognized schools of the practice of medicine in this State to appoint a representative who should be paid by the State; whose qualifications should be thoroughly established by competent civil service examination; whose duty should be to visit without notice to the owners at not too infrequent intervals, the various places where vaccine virus is prepared and make careful investigation, and examination of the animals; the method of feeding and caring for the animals; the conditions of cleanliness as shown in all the surroundings and all the stages of preparation of the vaccine virus; the care taken in examining and testing the virus before it is offered for sale and the printing and mailing to every physician in the State of their several examinations at least once every three months."

I believe that such a committee could be very useful to the physicians of the State and aid in protecting the citizens of the State from the perils of a loathsome disease.

I desire to enter my protest against the unseemly bickering among the vendors of vaccine virus and the unfair advantage which one house seems inclined to take of another. I have used the vaccine virus of different houses and believe the product presented for the use of the profession is generally pure. On my own person and upon the members of my family I have used that prepared by the H. K. Mulford Company, of Philadelphia, and have found it eminently satisfactory. But I am not here to favor or advocate one manufacturer above another, but I do believe that as physicians, it is our duty to inform ourselves as to the conditions under which the vaccine virus we use is prepared and to know through our own representatives, that the utmost care is taken to prevent any unnecessary danger from vaccination.

I believe that vaccination is, in a sense, at a crisis, and unless intelligent practitioners, who believe it to be a scientific method for the prevention of disease, rally to its support, that the hands upon the clock of medical progress will be turned backward many years.

Akin to this subject, if not directly related to it, is the somewhat novel method of treatment recommended by Dr. T. C. Osborne, of Cleburne, Texas, and published in the February number of the *Medical Council*, of Philadelphia. Dr. Osborne believes that small-pox is never transferred from one individual to another except by actual contact. Never by the atmosphere. He believes that the bichloride of mercury in a solution of one part mercury to two hundred fifty of water is a marvelous prophylactic, and that it is not a dangerous



application when applied to the skin of the individual suffering from small-pox. That by protecting the facial cavities, the eyes, nose, mouth and fauces, and sponging the body thoroughly with this solution, all cases of incipient small-pox may be aborted in from twenty-four to forty-eight hours. He advises freely spraying the eyes, nose, mouth and fauces with peroxide of hydrogen. He claims to have treated a large number of cases without a single death and rarely has one continue more than forty-eight hours. He claims that the spread of the disease is at once prevented. That his method is safe and certain. He advises internally the use of thirty grains of hyposulphite of soda in a half a glass of water once a day, to cleanse the stomach and act as a gentle laxative, and the use of this sponge bath of solution of bichloride of mercury twice a day.

This method of treatment is certainly to many of us a novel one, and if experience proves its utility, it will not only come into general use, but will solve for us promptly and satisfactorily many of the problems which vex us in connection with vaccination.

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## DISCUSSION.

F. PARK LEWIS: *Mr. Chairman*, it may interest the members of the Society to recount a little correspondence I had with one of the representatives of the makers of vaccine, two of them, indeed, the Mulfords' and the Stearns Company. It occurred to me that, knowing by assurances, that the serum of animals which had been rendered immune to certain diseases prevented diphtheria, that it was not at all improbable that the serum taken from a vaccinated cow or calf that had been tested for tuberculosis, might also serve as a protective against vaccination, and if so, against small-pox; and I wrote to the representatives of these firms suggesting the idea that I had in mind, and saying that I should be very glad to make some tests. The Stearns people wrote me that their Dr. Henry had carried out experiments on those lines, and by tests made on Guinea pigs and rabbits he found that serum so used did serve as a protective, but for a very limited time, and offered to aid me with any facilities that their laboratory afforded in making further experiments; but I thought the mere fact that those experiments had been carried on and that there is literature written on it, which Dr. Henry is very willing to give to those who care to look into it, might be of interest to the Society. I have carried the matter no further.*

DR. LESEUR: I have been intensely interested in this subject, and Dr. Lewis has touched on what seems to me a very vital point. I believe we are intensely interested in knowing just what protective method is pursued in preparing the virus that is submitted for our

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*Vide *British Med. Journal*, Jan. 26, 1896, Vol. 1, P. 240.

use; and I took the liberty, and am glad to say that the Chairman of this Bureau endorsed and approved my action, of telegraphing to Philadelphia to a gentleman who is distinguished in this line and who gives his entire time to the work of examining and preparing and testing virus. He is in the room to-day, and I believe the members of this Society would be glad to hear from him, Dr. Elgin.

PRESIDENT GREENLEAF. *Gentlemen of the Society*, I have pleasure in introducing to you Dr. Elgin, of Philadelphia.

DR. ELGIN: *Mr. President, Ladies and Gentlemen of the New York State Homœopathic Medical Society*, I thank you very kindly for this invitation to present to you certain phases of this question which are probably better known to myself and those associated with me in this work than they could possibly be known to the ordinary practitioner. Permit me, however, as an introduction, to say that I was delighted with the paper that we have just heard, by Dr. LeSeur, which I think is really one of the best, one of the most conservative I have listened to on this subject, and one that merits your consideration. It does not take either side pronouncedly on this question, but it presents to you the facts which you have to work out for yourselves.

Now, gentlemen, before going into any other data in regard to this question, I want to take up hurriedly, because I do not wish to consume too much of your time, the method usually pursued by the ordinary vaccine producers in the preparation of virus, incidentally calling your attention to the tests that are made of the various products before they are put upon the market. In the first place, the specially selected calves, usually from two to three months of age, are obtained females preferably. After they have been specially selected they are clipped so that the long hair will not become soiled with discharges. They are given a bath with a strong alkaline soap solution. Then the tuberculine test is applied, which it is unnecessary to go into here, as you probably all know what that is, but that shows absolutely that they are free from tuberculosis. Recently, however, of about eighteen thousand post mortems on calves that young in Paris, not a case of tuberculous lesion was found, so that you can see it is comparatively rare to have tuberculosis in a calf of that age.

After these preliminaries have been gone through with the animal is sheared on the posterior and abdominal regions, is cleaned thoroughly with soap and water, and then with a bi-chloride solution of 1 to 1,000, which is carefully washed off with sterilized water, and I say "carefully washed off," because we have found that physicians, as a rule, are sometimes a little careless along this line, and wonder why virus does not take. We do it as a routine procedure, regularly, and so do quite a number of other producers, and are not afraid to use it where it is properly removed before the virus is applied. After this is done the hair surrounding the scarified area, or the area to be scarified, is covered with sterilized towels which have been placed under fifteen pounds steam pressure for half an hour. Then the operator, preparing himself according to well known operating room



methods, makes with the ordinary scalpel incisions along this abdominal region, drawing no blood. The whole region, probably as much as a foot and a half square, is scarified with linear incisions about one-fourth inch apart, drawing no blood, over the whole area; and, gentlemen, that is just one point that I wish to emphasize especially, in all your technique of vaccination. Although I have no doubt that nearly every one of you has his special technique for this work, there is one point you should emphasize, and that is, do not go down into the deeper tissues. It is absolutely unnecessary, and you will sometimes find that, with aseptic vaccine, with practically aseptic technique, you will get results that will surprise you in the sore arms that do result from this form of virus, and with the best surgical procedures, just from the fact that you do go down into the subcutaneous tissues. Please remember that all that is necessary is to remove sufficient of the scarf skin to establish close and intimate association with the absorbents. Do not go any deeper. Some of you may doubtless remember, and I see Dr. Pease is present, who will bear me out in the statement, that there is on the skin of man, as well as of the calf, an organism, as has been proved by Dr. Welsh, of John Hopkins', known as the staphylococcus epidermitis. Please remember that that is not only on but in the skin, so that you may use bichloride of mercury all you please and you will not absolutely destroy it. I believe when you carry this organism from its normal habitat, along with the virus, into the subcutaneous tissues, even if only slightly below the epidermis, one seems to react on the other, and consequently a very much sorer arm results than would otherwise be the case, when only very shallow incisions are used, drawing no blood.

Then, again, after these incisions are made, glycerinated virus which has been previously tested, to find that germ life has been removed, is rubbed into these scarifications with sterilized instruments. The animal is returned to the incubating stables and allowed to remain there five days under the strictest aseptic precautions in which it is possible to keep the stable. Boiling water is used to flush the stable every day, an attendant is always ready to look after the health and condition of the animals, the temperature is kept at from fifty-five to sixty degrees, and all of the surrounding conditions are such as to render the animal as nearly perfectly clean as it is possible to have it. At the end of about five days, sometimes six, we will find that along these lines of incisions have developed pearly white vesicles with slight depressions in the center and very slight areola around them, also a beginning crust or scab formation. At this period the animal is again removed to the operating room. The surface is soaked until the beginning crust formation is softened and easily removed with a sterilized instrument, leaving the lines filled with the pearly white vesicles before noted and a very limited area of inflammatory condition. You do not find the great necrosis of tissue that has been described in discussing this form of vaccination on animals. After this has been surrounded by sterilized towels and washed carefully with sterilized water, and the usual technique of the operating

room has been complied with, the operator, with a Volkman spoon, or curette, follows along these lines of incision and scoops out the vesicle and its contents, consisting of epithelial tissue, a certain amount of serum, along with a large number of bacteria, some few red blood cells and some few white blood cells, but no deep necrosis of tissue. This material is carefully weighed in order to calculate the amount of glycerine and distilled water to be added to a given weight of "pulp." This material is then ground with a specially constructed sterilized machine, with glass rollers, and a perfectly homogeneous mass results, and the skin tissue is also pulverized so as to bring the glycerine into good contact with every particle of material. It is then put in large "stock" tubes, hermetically sealed, which are placed in cold storage for about four weeks, when it is examined microscopically to see the condition as to the number and character of the bacteria which it may contain. Just along this line permit me to say that the experiments have demonstrated to me that the temperature necessary for the storage of glycerinated vaccine, in order that the bacteria may be destroyed, is an important point. When put in a temperature of from zero minus to 15 C. the bacteria will not be destroyed in six months. I have taken material that has been kept six months at that temperature, and from an ordinary loop of glycerinated vaccine have grown as many as 10,000 colonies at the end of that time, while vaccine that has been stored at from 11 to 13 C. plus, and kept at that temperature, has been absolutely free from bacteria. So that even a question of this kind must receive its careful consideration.

After this bacteriological examination has been made, it is tested on the animal to see whether it is active, because it is a well known fact that if active on the calf it must necessarily be active on the human; and vice versa, it will sometimes take on the human when it will not take on the calf, because the calf is the more resistent animal. The last test is on the guinea pig. About one hundred times the quantity used to vaccinate a human being is inoculated into the guinea pig. If the animal remains alive and well at the end of one week, we are satisfied that the virus contains no injurious substances, since the guinea pig is one of the most delicate animals that we can use for test purposes, and as all of you doubtless know, it is probably more susceptible to tetanus as well as other acute infections. After that test is made, it is then drawn into capillary tubes by a special pressure apparatus, or the points are charged with this glycerinated lymph. The capillary tubes are recommended as probably the best form because they are hermetically sealed glass, and cannot be opened until in the hands of each consumer.

This practically concludes a description of the ordinary technique as employed by reputable vaccine laboratories. It simply illustrates to you the care that is taken both in the preparation of the vaccine virus and in its protection at the same time. There are a great many questions of interest that could be gone into—this question of tetanus, the question as to what vaccine is, and what it is not, and quite a number of other questions that would possibly be of



interest, but I do not know just what lines would suggest themselves to you as being desirable to take up; and so if it is agreeable to the chairman I will pause for a moment for questions along that line and if there is anything I can answer I will be very glad to do it. If not, I will not take up your time further.

DR. MOFFAT: Did I understand the doctor to state, Mr. Chairman, that it is accepted that they have found the vaccine bacterium?

DR. ELGIN: No, sir.

DR. MOFFAT: You spoke of the number of bacterium in colonies.

DR. ELGIN: The most common bacterium found in vaccine virus—and there are millions on top of millions, after the most careful preparation, when it is first removed from the calf—is the organism I have just suggested, the staphylococcus epidermitis, which is not only on but in the skin of the calf, and, of course, must be in the vaccine when taken off. That is always present. The hay bacillus is also a contamination, but is of no consequence except that it gives quite a good deal of trouble in laboratory work. The staphylococcus aurius is found in about twenty per cent. of cases. Of course, it is not clearly defined as to the difference between the staphylococcus albus and the staphylococcus aurius at the present time. Our text books give us quite an extended discussion along that line, but it has not been clearly worked out in my judgment. At any rate, in about twenty per cent. of the cases, that is present and it is usually in attenuated form. Just along that line I wish to state that the use of glycerinated lymph in this country has had its best results in the vaccination of animals. Prior to the introduction of glycerinated virus in this country, the vaccination of the animal was done with the old dry point, or "seed spade." These were charged from one animal, and the second was vaccinated therewith, carrying from one animal to another the vaccine perhaps, but at any rate the germs contained on the seed spade, or point, along with the vaccine. Now, you gentlemen probably know that in bacteriological work, when you wish to intensify a germ you pass it through live animals. For instance, if you wish to intensify the germ of pneumonia or erysipelas, a bouillon or beef tea culture is prepared, and it frequently requires as much as two cubic centimetres or more to kill a rabbit, where by passing this same culture through a number of such animals, it becomes so toxic, or poisonous, that 1-100 of a cubic centimetre or less will kill an animal of the same size in from thirty-six to forty-eight hours. Incidentally we were doing the same thing with vaccine. We were passing the contained germ from one calf to another over and over again, and the result has been that I have seen calves inoculated in this way on which, in twenty-four hours after inoculation, there would be pus running down their legs to the floor. We do not see that now, and I think if there is any single advance that has been made in preventive medicine along this line which we have received from the old country, it is in the use of this glycerinated lymph, not only to vaccinate people but more particularly to inoculate our calves for the propagation of the virus. I am making this statement from the standpoint of preventive medicine, because from the standpoint

of commercialism we would very much rather dispose of the dry points, because there is quite a percentage of profit in the production of the dry points when sold in quantities, while the cost of the glycerinated very much exceeds that of the dry form; but undoubtedly the very best form in which the virus can be prepared at the present time is that of the glycerinated product.

DR. TERRY: I would like to ask a question. Is this glycerinated vaccine free from living germs?

DR. ELGIN: Not absolutely, no, sir.

DR. MOFFAT: May I ask one question? I understand that in preparing it they snip the whole skin tissue out with it.

DR. ELGIN: Yes.

DR. MOFFAT: Has it been found that they cannot get a sufficiently reliable vaccine by withdrawing only the lymph? or is it not practical? Are they so small that they cannot get the lymph without the rest of the tissue?

DR. ELGIN: *Mr. Chairman,* I would be very glad to answer that question, but it will take me about five minutes to do so.

(On motion, duly seconded, the time was extended.)

DR. ELGIN: I am very glad that question has been brought up, because I think it is an extremely important one. According to the older American methods of vaccinating we used a square cut both ways. That was inoculated by the plan of which I have already spoken, and by the old-time seed spade, together with the bacteria which it contained. Now, in twenty-four to forty-eight hours you would find that puff up. After about three days' time you would find that by running a sterilized instrument or knife around the edges, you could lift that whole area up, the scab or crust, and the skin with it, and beneath it would be found quite a big sore, which we used to call laudable pus. You all know what laudable pus is, as we at present regard it. That was sponged off, drawn into capillaries, excluding the blood, and the serum was charged with a sterilized brush, on ivory points. You can readily see that if this produced this immense amount of necrosis of tissue, you could not separate it by sponging, but you were putting your bacteria on your point at the same time you were putting on your serum. I now come to the point of the doctor's question. If the serum were the part that vaccinated, we could cut the jugular vein, take the blood and separate the serum, just as we do with antitoxin, but unfortunately it won't vaccinate. If you take that serum and run it through a filter, taking out the solid particles, the serum that goes through won't vaccinate. The solid particles that remain behind will. So what is the sense of throwing away all the solid particles we can see and depending on the few that we cannot see? Doctor, have I made that clear?

DR. MOFFAT: No, not quite. You say that the serum of the pock itself would not vaccinate?

DR. ELGIN: The serum alone, without the solid material, as has been demonstrated, would not vaccinate—the serum alone, such as you get from suction through a vacuum tube.



DR. MOFFAT: Wouldn't that be less dangerous than the scraping off of the tissue?

DR. ELGIN: I think not, doctor. I can imagine nothing in skin tissue that is especially dangerous. There must be some germ which the skin contains, which must also be contained in the serum.

VICE-PRESIDENT HAINES: It has been suggested that the chair call upon Dr. Pease, who is connected with the State Laboratory, to state to us briefly some facts with regard to the preparation of these materials.

DR. HERBERT D. PEASE, of Albany: *Mr. Chairman,* I am not engaged in the manufacture of vaccine for the State, but I have had the pleasure of inspecting two of the largest vaccine establishments in America. One point I should like to bring out concerning the manufacture of biological products in general is that the best safeguard the public has against impure material is to be assured that the man at the head of such an establishment possesses an aseptic conscience. Any amount of temporary inspection can only produce information as to defects existing at that time. It does not prevent defects which may come up at any time. The chief difficulty with the manufacture of products of this character is the occasional, unlooked-for, temporary break in technique. That cannot be provided against by temporary inspection. Of course, the opportunities for such breaks are reduced to the minimum by frequent inspection, but the chief and the best safeguard against the occurrences of trouble with biological products is having the work under the management of a man who has an aseptic conscience. I think there is very little possibility of disasters occurring at the present time in the establishments manufacturing biological products. The risk taken is altogether too great for them to have anything but scientific men at the head of such establishments, and the financial support obtained from the sale of their products is such as to enable them to engage men who are capable of undertaking this work. The points Dr. Elgin has brought out concerning the staphylococcus epidermidis albus, are most excellent. That an increase of virulence occurs when an organism is transferred from one animal to another is established without question. The older forms of vaccine undoubtedly contained this organism in a more virulent form than does vaccine at the present time. This organism is not ordinarily virulent for human beings. It occasionally causes a small amount of suppuration. The common stitch abscesses are caused by this organism in the majority of cases. However, they are usually of insignificant importance; the abscesses amount to very little. The presence of a few cocci in vaccine, therefore, is really of no particular consequence under present conditions. The older methods of preparing vaccine, as you know, did produce an organism that was more virulent. As to the presence of the tetanus bacillus in vaccine, it was most irrational to suppose, as many did during the recent scare, that such organisms were present in vaccine. The rational explanation of the recent cases of tetanus following vaccination is that the tetanus bacillus

gained access to the wounded tissues through the carelessness of the vaccinator or more likely through the grosser carelessness of the person vaccinated. Any other suppositions are untenable. In view of the recent scare I have recently advised that protective doses of tetanus antitoxin be administered at the time of the vaccination of persons known to be uncleanly or unable to properly care for themselves, especially when such persons live in regions where tetanus is endemic. Such a precaution would absolutely prevent the occurrence of tetanus. In regions where tetanus is prevalent, and where the persons vaccinated are known to be careless, they should be so protected for the benefit of the cause of vaccination. (Applause.)

DR. MOFFAT: *Mr. President*, I think Dr. LeSeur's paper is exceptionally important, and I move that the recommendations contained therein be referred to a special committee to report at their early convenience. (Carried.)

DR. MOFFAT: The other day one of the public vaccinators in Brooklyn asked me if I would care to have some vaccine virus. I said, "Yes." He took from his case a large-mouthed, half dram vial with maybe half a cubic centimetre of glycerinated lymph. Every time it was opened the whole surface of the vaccine was exposed. He told me that the habit in public vaccination is to use a separate toothpick for each patient. I do not consider that this is up to date and properly protective from possible contamination. I never vaccinate without applying a large celluloid shield immediately. Dr. Pease suggested the probability, and I believe he is correct, that most of the trouble from the old-fashioned vaccination comes from contamination by the patient; and I offer the following:

*Resolved*, That in the opinion of this Society, when the State or local authorities enforce vaccination they are in justice bound to surround it with all the modern safeguards;

*Resolved*, That public vaccinators should properly apply an efficient shield immediately upon vaccination, with instructions as to its care and removal;

*Resolved*, That the virus used by them should in each patient be free from all possibility of contamination.

VICE-PRESIDENT HAINES: This would be in order at the close of the discussion. I will hold it until that time.

DR. LESEUR: *Mr. President and Members of the Society*. So much has been said that little more is to be or should be said at this time, when the Bureau has already occupied perhaps more time than it is entitled to, and perhaps more than it would be given were it not for the fact that this is a live question with every one of us. I think that Dr. Moffat has stated the pith of the question, and so tersely and well stated it that I need perhaps say nothing further. Cleanliness is next to godliness in a great many respects, and nowhere more so than in vaccination. I believe that it is worth while for the instructors in our various colleges to give some special direction



with regard to vaccination. I believe it has been too much neglected as to its technique. I believe our salvation lies along the pathway of a great regard for the strictest asepsis in the performance of this work. I believe that it is just as important for the physician when he is vaccinating a patient to have that patient report, to see that patient and know that that wound is properly cared for—just as important as General Terry regards it when he performs a laparotomy, to see the case next day; and I believe no physician is justified in discharging a vaccinated case until he knows of his own personal knowledge that that bit of vaccination has been properly done and the wound has been properly cared for. When we have that high conception of our duty as physicians and perform our duty faithfully in that regard, much of the danger of vaccination will have vanished into thin air.

M. O. TERRY, of Utica: *Mr. President*, in reference to the resolution offered by Dr. Moffat, it seems to me that if we are to believe the gentleman from Philadelphia who spoke, we cannot have absolutely pure virus, and therefore, it seems highly improper to have a resolution of that kind passed. I have not said anything in regard to vaccination to-day, but following through the paper read by Dr. LeSeur, I am impressed with my experience on the subject. I have vaccinated and it has taken in the case of a lady whose face was thoroughly pitted from the effects of small-pox, and history shows that immunity does not continue in the large number of cases for more than two years. In view of this fact it seems to me that the laws of the State and the ordinances enforced in our different cities and villages are inconsistent with this historical fact. That we should compel children when they enter the public schools to be vaccinated, and babies are vaccinated soon after they begin their first cry—it seems to me, gentlemen, not scientific, but a relic of barbarism, to enforce a law of that sort. I am not questioning the value of the effects of vaccination as a preventive against small-pox. It probably is a good thing when you have sufficient evidence of an outbreak in your city, village or town. But what do we find? One case will appear, and the whole town is under excitement, and the health officer and the physicians are all called upon to vaccinate their patients indiscriminately. The gentleman from Philadelphia who spoke and gave us so much scientific information, should have carried it still further, I think, and probably he would if he had had time. I would like to know the effect of the germs which exist in Mulford's or any of these vaccine preparations upon the organism. The question was put a few years ago in some of the societies of London as to whether or not the use of vaccine was one of the factors which induced the increased tendency toward cancer formations. Now, if such is the case, that a degeneration in the body goes on from the time of the vaccination, why should we not allow these little ones, born in good health, to go on and enjoy it, unless an epidemic prevails, necessitating this so-called preventive measure?

VICE-PRESIDENT HAINES: It would be very agreeable to the

chair, and I suppose, most of the members, if this discussion could be prolonged, but the time has long since passed when the next Bureau should properly have been on. I shall be obliged to close this Bureau, without a special vote, and proceed to the resolution offered by Dr. Moffat.

J. D. ZWETSCH, of Gowanda: *Mr. President*, just one minute. We had small-pox break out in our town just before the Pan American Exposition——

VICE-PRESIDENT HAINES: Doctor, you will be obliged to have a special vote before speaking any further——

DR. TERRY: *Mr. President*, I move that the gentleman be allowed to speak for five minutes if he wants to. This is an important subject. (Carried.)

DR. ZWETSCH: —— about in May. Being the railroad surgeon, I saw a case when it first broke out. I had never seen a case of small-pox in my life, but it struck me as peculiar, and I asked one of my brother practitioners to go out and see the case. He said: "Doctor, I think this is small-pox." We called in the old health physician, and so it proved to be. We had 185 Poles working in the canning factory, all sleeping in one building, on the floor, and on straw and on everything else. The town was very much excited, and Dr. Wende, the health physician of Buffalo, came out there, and he said: "Now, unless you quarantine these people we will have the town quarantined." We took those Poles down on the Reservation and vaccinated them, with the exception of three or four that escaped and got to Buffalo, and I think two of them got to Batavia, LeSeur's home; but all of those that were vaccinated escaped small-pox, and we had only seven cases, and they were all children. We vaccinated some 500 people, and we had no more cases. We had no bad results from the vaccination. I vaccinated some 200, and I used the tubes; didn't use the points at all, and both Mulford's, and, I think, Alexander's. In that way we stopped it among the Poles, a people that are filthy, and I think that is proof that vaccination is a pretty good thing.

DR. MOFFAT: Did you use shields?

DR. ZWETSCH: I used shieds, yes. I didn't have charge of these Poles. I believe unless you use a shield the underwear and all will contaminate the wound. I use shields and have no trouble in my cases. I use the celluloid shield, and have used another shield, of which I forget the name. I have had no trouble at all.



# WINTER IN COLORADO.

FREDERICK A. FAUST, M. D.,
COLORADO SPRINGS, COLO.

The climate of Colorado has long been famous, but it is only within recent years that attention has been given to the delightful winter climate of the State. To-day physicians all over the United States send their patients to Colorado to escape the rigors of Eastern winter, and to benefit by her invigorating atmosphere, and health-giving sunshine.

The diurnal range of temperature is great, and there are rains throughout the warm parts of the year, and snows in winter, but both are moderate in quantity. There are on an average 340 days in the year in which the sun shines, and persons suffering from pulmonary troubles have the benefit of bright sunshine at all seasons. To live in a climate where there are no winter rains, to be free from the chilling mists that haunt the seacoast from October to May, to enjoy the cloudless sky, and the long hours of sunshine through the months that we have come to regard as naturally stormy is a pleasure which, once experienced, can never be willingly relinquished.

We look at the majestic mountains clad in snow, the crisp air tells of a lower temperature at evening and perhaps a frost at night; the mountain streams may be frozen in sheltered canyons; but the same sun shines, the skies have the same unclouded blue, the air has the same softness, day after day, the same outdoor amusements are common as in summer, the same hotels stand open to offer hospitality to the stranger and invalid, and in all ways the pleasures and comforts of life remain as certain. It is the usual thing to sit in the public park in December, or to use the open porch as a sewing room in January.

The winter sunshine of Colorado is a mine of inexhaustible treasure from which we may draw the equivalent of life, health, money, population, and everything that goes to make up the great and prosperous State that Colorado is soon to become.

Dr. Solly, in his admirable work on medical climatology, says, in comparing the merits of resorts in New Mexico, Colorado and Arizona: "Colorado Springs preserves the most stimulating climate of all these resorts. The winter is, however, the season in which most cases of consumption reap the greatest benefit, the air being then extremely dry and highly electric with no rain and very little snow. The thermometer shows great variations between day and night, sometimes at that period going below zero, but the absence of moisture, and the shelter of the hills prevent any depressing influence from the low temperature being felt, and with a moderate amount of woolen clothing, only its bracing effect is felt upon the human body. During the day, from 10 till 4, the sun shines almost

uninterruptedly, and with sufficient power to enable even the enfeebled invalid to enjoy outdoor exercise, without additional wrap or overcoat, the hillsides around not acting as a screen to the sun rays, but as a trap, concentrating their effect.

"I will now proceed to sketch in outline the average day in mid-winter. After a night in which there has been a hard frost and a clear sky, with a light breeze from the North, and during which the invalid has usually slept soundly under several blankets with his window wide open, he wakes up to find the sun shining into his Eastern window. And this is a feature which, whatever the weather may be later in the day, is rarely absent. After breakfast our invalid steps into the street, being then in an atmosphere in which the heat in the sun is 92 F., and in the shade 30 F. A gentle air is stirring from the Northeast, at the rate of eight miles an hour. The mean dewpoint is 8. As the day proceeds the temperature rises to its highest point between 2 and 3 p. m., being 100° in the sun and 40° in the shade, while the wind, which has moved rapidly from the North to the South, blows with its highest daily velocity of thirteen miles an hour. After 2 p. m. the wind works back again toward the East, being at sundown Northeast, and continuing, as darkness falls to shift back to the Northern quarter, whence it blows from 8 p. m. to 9 a. m., its velocity dropping to between seven and eight miles an hour; the temperature at the same time falling from three to four degrees.

"In winter, as indeed throughout the year, there is more or less mobility of atmosphere, an absolutely still day being exceptional; but there is seldom in winter sufficient wind to make exercise disagreeable or dangerous, and on the majority of winter days, delicate invalids sit out upon their porches with pleasure and benefit. The fact is that we have a night wind from the mountains, and a day wind from the plains. We are, as it were, upon a seashore, the plains being the ocean, and the mountains the shore, with a land and sea breeze."

In the last ten years the records show that in Colorado Springs the sun shines for about sixty-two hours out of every 100 that it is above the horizon. There has been an annual average of 314 clear or partly clear days. In Chicago in the same period there were only 251, in New York 262. Instead of the fifty-one cloudy days in Colorado Springs, there are 129 annually in the Adirondacks, 106 at Asheville, 97 at Thomasville, 92 at San Antonio and 73 at Santa Barbara.

I take the following from my weather record this year, January 25th: Since the 28th of December every day has been cloudless with the exception of three days when the sun shone for only part of the day.

There is more building going on here in the winter than at any season of the year, carpenters, masons, etc., working day after day without interruption. During the past week forty-three building permits were issued, the work to be completed before spring.



Under the sanitary arrangements that have been put in force in our city in recent years, it has rapidly stepped to the front as one of the healthiest cities on the whole continent, and this in spite of the fact that its population is constantly added to by invalids from the extreme East. It is the whole testimony of the medical profession that a case of tuberculosis is virtually never developed in Colorado Springs or in any Colorado resort.

Much has been written of late about winter climate and summer climate, but often the most desirable thing is to find an all-year-round climate, and this is the possession of Colorado.

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# REPORT

OF THE

## BUREAU OF SURGERY.

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## TWO CASES OF LUPUS.

W. E. MILBANK, M. D.,
ALBANY.

DR. MILBANK: *Mr. Chairman*, Since Prof. Gilman, of Chicago, reported his cases of cure of lupus by the X-ray, I have been experimenting with it, and I presume everybody that has had an X-ray machine, or static machine, or any machine that would produce the X-ray, has also been experimenting, so I thought it would be just as well to bring these cases before the Society and show them the different stages of the disease, namely: cured, partially cured, and those that are just in the early stages of treatment. I have here

three cases of lupus. My case of cancer is not here. I have a case of cancer of the breast. It is either cancer of the breast or modulated gland. Whichever it is, it has been reduced. It was about as large as a good sized orange. At the present time it is about the size of an English walnut. The soreness has disappeared.

Here is a case (indicating) of fifteen years' standing which has been through all sorts of treatment, and it has eaten off part of the nose. You can see the line of demarcation all through here (indicating). The last time I applied the treatment I burned it accidentally, so that the inflammation extended close up to the eyes. You can see the condition of the wound at the present time.

DR. TERRY: Was that all ulcerated, Doctor?

DR. MILBANK: That was all ulcerated and eaten nearly through. Not only that, but it has granulated and filled up so that you can hardly distinguish the difference between the two sides of the nose.

DR. TERRY: There is a slight degree of ulceration there now.

DR. MILBANK: Yes, a very slight.

Here is another case of nine years' standing (indicating), as I understand, from a line just below the eye, ulcerated very badly, extending down three and one-half inches on the cheek and one and a half inches wide. It has been burned so badly with a hot iron that it burnt clear through to the bone, destroying the tissues. I have been treating this case, now, since the 4th of January. I have given her two treatments within two weeks. This skin, if you notice, is entirely loosened from the bone, and granulated. That is all granulated in forming new tissue and a healthy skin (indicating).

DR. TERRY: Was that surface entirely open when you began?

DR. MILBANK: That surface was entirely open and was adhered to the bone. Where it had been burned so badly with a hot iron it adhered to the bone, so that there was no possibility of moving it. After three or four applications of the X-ray it began to loosen up and granulations began to form. It is not entirely well now. It will scale off again; that white surface will scale off, the same as it has in the other case.

DR. TERRY: How often do you make the applications?

DR. MILBANK: I have made the application sometimes every day, and sometimes every other day, just as the conditions required.

In reply to questions by several members, Dr. Milbank stated that the whole surface involved in this case was a granulated mass when the treatment began, with no epithelium on it; since beginning, on January 4th, there have been eleven treatments applied to date, each treatment being from five to six minutes in duration; no application or dressing being used, with the exception of plantago ointment to keep the cold from the parts when the patient came to the office, and to soften them. To surround and protect the healthy tissue lead was used.

DR. MILBANK: (Presenting another case.) Here is a case of only one year's standing. When I saw the case the end of the nose was about the size of an ordinary snow apple, dark purple color, and the affected area extended clear up to the eyes (indicating). Both



the nostrils were entirely closed. She had not breathed through her nose for nine months. In the morning her tongue would bleed from the dryness. I applied, I think it was, about four or five treatments, when she began to breathe through one side (indicating). The disease extended from the eyes, the entire nose, the left half of upper lip and part of chin. You can see the lines down under the lip. I burned that accidentally one night—burning my fingers at the same time—but I think it did it good. It was the best thing that could have happened. About a week ago this was all cleared up entirely. I neglected the treatment on account of the burn, not knowing the nature of the goods I was handling. This looks a little red (indicating), although there is a little ointment on there now. In about three treatments more that will dry up. In one treatment it will dry up so that you can notice a marked difference. This scab will drop off and leave a healthy condition underneath. That is a recurrent case.

DR. WILCOX: Will you give us a little description of the technique, Doctor—the length of time? the distance the tube is from the face?

DR. MILBANK: I apply it at a distance of from two inches to a foot, eighteen inches, according to the color of the X-ray tube.

DR. TERRY: What do you mean by that, Doctor?

DR. MILBANK: According to the difference of the color. A green color will burn very quickly and destroy very rapidly.

DR. TERRY: That you would put off eighteen inches?

DR. MILBANK: That you put off a long distance. If it is a very light green you can apply it within two inches and hold it there a couple of minutes, and then gradually pull it away.

DR. TERRY: Can you see the effect of this—

DR. MILBANK: You can see it dry immediately.

DR. TERRY: So that you can increase the distance, or the action, by the effect you get?

DR. MILBANK: Yes. You can see the grease boil out of it when you apply it too closely, just the same as a burn.

DR. WILCOX: How as to the length of the treatment?

DR. MILBANK: I give it from five to ten minutes.

DR. WILCOX: And the frequency?

DR. MILBANK: Sometimes every day, sometimes every three days, sometimes once a week. I skipped this case for two weeks because I had burned it badly, but the burning is what did the work.

DR. TERRY: From your experience how long will it take to cure that case?

DR. MILBANK: I think in another month she will be entirely cured.

DR. WILCOX: You protect the rest of the face with the lead?

DR. MILBANK: With the lead, thoroughly.

A MEMBER: Do you mean the ordinary tin foil?

DR. MILBANK: I used the tea lead, which you can mould better than the ordinary tin foil. I did use the tin foil at first, but now I use the tea lead. That you can press down in the different places around the face.

DR. TERRY: Is it a painful treatment?

DR. MILBANK: Not at all; never feel it.

DR. TERRY: Does the patient feel it in the head at all?

DR. MILBANK: Not at all. The only feeling they experience will be where the lead is a little distance from the face. That will produce a little electric spark.

DR. MOFFAT: The burn is painful, I suppose?

DR. MILBANK: The burn is very painful and very deep. I can demonstrate that right here. I burned my two fingers and this thumb. Now that skin is dead, and it has peeled off once. It shows what effect it has on the tissues. You see the difference (indicating).

DR. GORHAM: What do you use to cure the burns?

DR. MILBANK: Plantago ointment.

DR. WILCOX: *Mr. President*, I move that a vote of thanks be extended to Dr. Milbank for the presentation of these cases which are so interesting and instructive. (Carried.)

(Applause.)

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# FURTHER OBSERVATIONS ON THE VALUE OF THE MEDICATED GALVANIC CURRENT ON VARIOUS GROWTHS.

M. O. TERRY, M. D.,
UTICA.

In the July issue of the *Medical Times* for 1900, there is an article which came from my pen on the resolving effects of the medicated galvanic current on various growths. The treatment suggested was the result of years of observation, although there was no extensive clinical report supporting the article, yet the character of the difficulties treated was of such importance to the general practitioner, the electrician, as well as the surgeon, that I have thought it advisable to reimpress it upon the medical profession by bringing it before you in a different way.

The growths referred to include enlargements of the cervical glands, fibroids, subinvolution of the uterus and goiter. All of these conditions are surgical in the sense that the surgeon is called upon to operate for the relief of those morbid processes. The operations in some instances are dangerous and in others an unsightly scar remains.

A trial of electricity, as will be described, involves no danger to the patient as the growths are slow in forming. It requires no great skill; the method of treatment is simple; the element of patience only being necessary.

Cervical enlargements will disappear more rapidly than the other conditions. In the case reported, where there were twenty-eight



cervical enlargements only three remained after three months' treatment. A goitrous condition disappears more slowly, it taking from six months to two years to bring about the desired result. This is also true in regard to fibroids and subinvolution of the uterus.

Much has been written of late in respect to prostatic hypertrophy and quite radical methods have been instituted for the relief of the same. There can be no reason why the galvanic treatment in such cases would not meet with the same satisfaction as in the others mentioned.

As to the method of application it will depend upon the growth to be treated. The electrodes are medicated in every instance by the use of chloride of ammonia and iodine. No particular attention is given as to the quantity of these remedies, but a drachm of the former with ten to fifteen drops of the latter is sufficiently definite. The strength of the current may be from 50 to 1,000 milliamperes. The patient is usually able to state the strength of current agreeable. It can be increased or diminished during a treatment, which may be from fifteen to twenty minutes.

In the treatment of fibroids of the uterus, where there is a marked hemorrhagic tendency, the negative pole is placed upon the spine or abdomen; generally the latter. The positive pole is applied by using a uterine electrode into the uterus, the part passing through the vagina being isolated by slipping over the electrode a piece of rubber tubing. Should hemorrhages be severe on beginning the treatment it may be given for two or three days in succession; then every five to seven days.

It has been before mentioned that a fibroid of nine inches has been reduced to four and one of six to three within a few months, and within the past five months a case has been treated by me where the hemorrhages had been persistent for weeks. They have long since ceased and the uterus which was six inches in length, reaching up to the umbilicus, is scarcely above its normal position now. The patient, who was an invalid, unable to work, expresses herself as feeling better than she has for months, and is able to resume her normal occupation.

It will be noted that the positive pole is used when hemorrhages are present, but in case of subinvolution the reverse is the proper treatment, namely, the negative to be placed in the uterus. Later on in the treatment continued resolution will be induced by using both poles upon the abdomen, pressed on either side of the tumor.

If prostatic difficulties were to be treated the positive pole should be placed upon the spine, the negative upon the perineum. I shall certainly try this treatment at an early period in case I should fail in the use of chloride of ammonium, which I have used for years with marked success in such difficulties, a report of which will be found in the Transactions of the State Society. The doses given in such cases are from eight to ten grains three times a day.

In conclusion I am quite sure that the practitioners, surgeons or electricians who will undertake this method of treatment with per-

severance will be as highly gratified with the results which follow as have attended my observations for the past fifteen years or more. (Applause.)

## DISCUSSION.

DR. FAUST: I would like to ask Dr. Terry what kind of uterine electrode he uses when the uterus is six or eight inches long. Does he use that which goes to the top of the uterus, or does he use the ordinary electrode?

DR. TERRY: I have a uterine electrode made of copper, I should think ten or twelve inches long, so that I can pass it as far as I desire, and then over that I slip a rubber tubing, just sufficient that the tubing goes as far as the cervix.

DR. FAUST: You carry the electrode to the fundus, of course?

DR. TERRY: Up to the fundus, yes.

## MODERN ANÆSTHESIA.

ANSON H. BINGHAM, M. D.,
NEW YORK CITY.

So much has been said and written on the subject of anæsthesia that everybody in the profession is familiar, at least theoretically, with the subject. And it is not my intention to rehearse the matter after the fashion of a text book, but to present a few facts which have proved especially valuable to me in this line of work, with a description of one of the later and more modern methods of producing ether anæsthesia.

The improvements in anæsthesia have been slow as compared to the rapid advancement in surgical technique, and until recently, the original methods employed by Dr. Morton in 1846 have been in universal use.

Any agent which is capable of producing unconsciousness and insensibility can never be entirely free from danger and the anæsthetist must be ever alert, and able to recognize those signs which fortunately in the majority of cases precede and give warning of the approach of danger. But in spite of all these precautions the unexpected will sometimes happen through no fault of the anæsthetist, but by a careful study of the subject he should always be ready to act and to act quickly, for the loss of a few seconds may mean the life of the patient. By a careful physical examination of the case before the operation the anæsthetist is often able to foresee the



dangers and by the proper selection of a suitable anæsthetic guard against them.

The St. Bartholomew Hospital reports collected by Dr. George Gould place the mortality of chloroform as 1:1502, ether 1:2830, and in ether when preceded by N2 O2 as 1:12941. These statistics would seem to indicate that the combination of N2 O2 and ether was the safest of all methods and it is on this subject that I wish to devote my time, believing as I do, that this combination possesses all of the elements necessary for up-to-date anæsthesia.

The low mortality of N2 O2 is accounted for by the fact that unlike the other anæsthetics it is an inert substance, and in the production of anæsthesia, it acts by shutting off the oxygen from the blood; it really produces a mechanical asphyxia, but as there is no poison circulating in the blood, the nerve centers are always ready to respond to the stimulation of oxygen. Unfortunately, however, the shortness of its action, the difficulty in obtaining complete relaxation, the muscular spasms which accompany its use, and the ununiformity of its action, limit its use in general surgical work to those cases requiring but a short time, although the anæsthesia may be somewhat prolonged by allowing the patient an occasional breath of air as soon as the twitching occurs.

It is in the commencement of the anæsthesia that gas has proved to be of the greatest utility. To start the case with the administration of N2 O2 and when the patient is fully under its influence, to substitute for the feeble action of the gas the more powerful action of another anæsthetic in the shape of ether. This constitutes what is known as the combined, or gas and ether method of anæsthesia. This method has become very popular, and I think deservedly so, for those who have employed it must be pleased by the results obtained, and certainly by the primary use of N2 O2 the surgeon's time and the feelings of the patient are spared to a great extent, and the disagreeable preliminary stages are made as short as possible.

The thought of the operation and its dangers is foremost in the mind of the patient, but hardly secondary to this is the knowledge that she must submit to an anæsthetic, which, in her mind and according to tradition, is always associated with all the horrors of suffocation and strangling. The patient generally comes to the hands of the anæsthetist in a nervous, excitable state, but she may be assured with perfect truthfulness that she will experience nothing unpleasant, that she will meet with no difficulty in breathing, and that the odor of the ether will at no time be noticeable. After having done all that is possible to gain the patient's confidence the gas inhaler is carefully and comfortably adjusted, great care being taken to exclude all air. The patient is requested to breathe naturally, and after a very few respirations, the muscles relax, the face becomes slightly cyanotic, the breathing becomes deeper, more regular and rapid, gradually changing to a stertor with twitching of the muscles and insensitiveness of the conjunctivæ. At this stage the change from gas to ether is rapidly made, and the patient passes into complete surgical anæsthesia without a struggle.

The entire success of the procedure depends upon the rapidity and dispatch with which the change is made, and the ether must be substituted in such a way that the patient has no chance to breathe any fresh air, for owing to the transitory action of the N2 O2, an inhalation or two of air would destroy its action. In other words, the object in view is to turn on the ether at such a rate that a full dose is being inhaled at the exact time that the muscular twitchings produced by the N2 O2 are first observed. The sudden inhalation of ether vapor will commonly produce a spasm of the larynx, but this will quickly pass off and the patient will rapidly come under the influence of ether.

The time ordinarily required to produce complete anæsthesia by this method is from two to three minutes. It requires a little practice on the part of the anæsthetist before he becomes familiar with the technique, but while the first few attempts may be discouraging, the results finally obtained are ample compensation.

I have carefully questioned a large number of patients after the operation and without exception they have all declared that at no time were they conscious of the sense of suffocation which is so commonly complained of, nor were they able to recognize the fact that ether had been substituted for the gas.

Most of the accidents of anæsthesia occur during the excitable stage, when, owing to the struggles of the patient, the respirations become deepened to such an extent that the lungs are apt to become overcharged with vapor and so lead to sudden respiratory and circulatory failure. This dangerous stage being absent when the combined method is employed, reduces the danger to a marked extent.

Under the old method it was the rule to strap the patient to the table, and during the excitable stage it was frequently necessary for one or two orderlies or nurses to be on hand to restrain him, and prevent his injuring himself. I have seen such patients get up from the table when these precautions were neglected. The combined method enables us to dispense with the help of others in restraining the patient. The initial vomiting which is so frequently a cause of delay and danger in ether anæsthesia is absent.

In the case of children where it is frequently impossible to gain their confidence, it is necessary to use force in the beginning; but it is of short duration; for children who appear to be especially susceptible to the narcotic effects of N2 O2, become completely relaxed after the second or third breath; in fact, the very act of crying and struggling so deepens respiration that N2 O2 narcosis is all the more quickly produced.

There is one class of cases where the administration of N2 O2 is not advisable, owing to the great increase in arterial pressure which takes place. I refer to those cases where there is present marked atheroma. There are on record several cases of this description where paralysis followed the administration of N2 O2, due to rupture of a diseased vessel.



In the employment of this method, either the closed or open inhaler may be used. The great advantage possessed by the former is that the change from gas to ether, is more rapidly made, and without removing the inhaler of this class the Clover and the Bennett gas and ether apparatus are good examples. I have used the Bennett inhaler almost exclusively and have every reason to feel satisfied with the results. Many surgeons object to a closed inhaler on the grounds that the patient does not receive a sufficient supply of air, but with the proper knowledge of the mechanism of the instrument, cyanosis is seldom observed. Another advantage of the closed inhaler is that owing to the small amount of ether required to maintain complete anæsthesia, the post-operative nausea and vomiting which is so frequently a serious complication is greatly diminished. But it does not matter whether the closed inhaler is used or an open case is substituted. The results obtained are the same; and the advantages it possesses cannot but appeal to those who are interested in surgical work.

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## DISCUSSION.

DR. TERRY: I was very glad to hear the theory advanced by the doctor in reference to the action of nitrous oxide, that it shut off the oxygen. That is a great objection to it as an anæsthetic. The surgeon often has cases put upon the table that are very anæmic, very weak; they have heart difficulty, the lips are blue, showing the condition of the circulation. It seems to me, theoretically, that an anæsthetic of that sort, mixed, if you like, with ether, is objectionable as such to give to a patient of that sort. In Utica Dr. Haines, your Vice-President, has given anæsthetics, using chloroform and oxygen combined. We have tried this for years. I do not recall any accident owing to the anæsthetic. Given a case such as I have described, anæmic, weak and a dangerous person to give an anæsthetic to—I have seen their lips become red under the anæsthetic administered, the chloroform having the oxygen volume pass through it. The doctor could give you minute details in regard to it, but off-hand it takes only about three to four minutes to give the anæsthesia, and about as many minutes for the patient to become conscious, and no unpleasant after effect that I have ever seen. The smothering feeling is not noticed. They go into it as gently as a child, and sleep in most instances. I hope the doctor will get up sufficient ambition to give you at our next meeting a report in detail and the number of cases that he has ministered to, showing you that this is a combination as an anæsthetic above all others.

Now, ether cannot be administered with impunity in a certain class of cases. I gave it for a great many years of my life, and until we began this method of administering oxygen with chloroform I thought it was the safest anæsthetic we had. You take a person predisposed to apoplexy, persons who are of large build, robust, and

made up in that sort of a way, persons who have bronchial difficulties, lung difficulties—it has been my observation those persons did not take an anæsthetic of which ether was the foundation very nicely, and I for one, unless I saw a good extensive report as to the number of cases without any trouble resulting, should be loth to change to the method which the gentleman has brought before the Society in this paper for us to adopt. (Applause.)

DR. BUCHANAN: *Mr. Chairman*, I have had in the last five years some 200 cases of chloroform and oxygen anæsthesia, and I can corroborate all that Dr. Terry has said about this method of anæsthesia. I believe it is the ideal method. There are some cases, however, in which chloroform would be a dangerous anæsthetic to give, whether supported with oxygen or amyl-nitrate, and those cases are where you have reason to suspect a myocarditis. I have frequently given chloroform and oxygen in cases where there was an endocarditis, without any bad effects whatever. In these 200 cases I have never seen a patient struggle. They just drop off as if going to sleep, and it certainly lessens the post-anæsthesia nausea. I do not believe I have had a case where the patient was conscious of vomiting. They have vomited once or twice before they were thoroughly out from the effects of chloroform and oxygen, but I never had a case in which they were conscious of having had any nausea following it.

Dr. Bingham has spoken of two methods in the use of nitrous oxide and ether, one the closed method, using such inhalers as the Bennett or the Clover, and the other the open method. I have used the open method entirely—or I won't say entirely, because I have given the closed method a trial. I have used the open method by giving the laughing gas with the ordinary inhaler, the S. S. White, and following that up with the open cone. There is no one in this room that would think of breathing in and out of a rubber bag, because you double the carbon dioxide in that bag each time, and it adds shock, and it certainly asphyxiates, and carbon dioxide acts as a paralytic to the nerves of respiration. The New York Hospital's anæsthetists report that after using the closed inhaler, they have found a greater percentage of albumen in the urine than they did when they used the open inhaler. The claim is made for the closed inhaler that you use less ether, while Turnbull, in his work on anæsthesia, says that the Allis open inhaler is the most economical inhaler that is used for ether. I have found it so, having no trouble at all to keep a patient under from one to one and one-half hours on three and one-half ounces of ether. I never had any trouble in keeping them under, and thoroughly under.

Just a word as to the signs in giving an anæsthetic. I have gone entirely upon the pupil signs, of course paying due attention to the respiration and condition of the pulse; but where you have a dilated, movable pupil, it is a sign that your patient requires more anæsthetic, and these signs apply to all anæsthetics, both nitrous oxide-chloroform, chloroform-oxygen and ether. A contracted, immovable



pupil is a state of ideal anæsthesia. A dilated, immovable pupil is a sign of paralysis of the third nerve and that you have gone too far, and you had better let your patient out, otherwise you may have an unfavorable result.

DR. SHERWOOD: *Mr. Chairman*, in my operative work at the Hospital of the Good Shepherd at Syracuse I have had an opportunity of watching the method described by the essayist during this last year, except that we use the usual towel cone for administering the ether; and I must confess that the results have been very gratifying. In all those cases where we would formerly have used ether, we have used it with less of the disagreeable features. The patient has taken less. As has been stated, the patient goes under the anæsthesia more readily, and the after effects, such as nausea, are less. As to the effect upon the kidneys, I have no data that would give us any precise information, but believe it would be reasonable to suppose it to be less harmful than when ether is used alone, as less is used by the combined method. I would say, however, that this method has been used in nearly all of the cases at the Good Shepherd for this last year, and it has seemed to us a great improvement over the method of giving ether alone. Of course, we have used chloroform in selected cases.

DR. HAINES: *Gentlemen*, if you will excuse my speaking from the chair—I had intended to compile some statistics and give you some facts in regard to my use of oxygenated chloroform, but I had not time to do it for this meeting. I was very much interested in Dr. Bingham's paper, and I believe that his method is a very good one; but I have had some experience in the use of oxygenated chloroform, covering a period now of nearly ten years, and to my mind it is the ideal anæsthetic. Chloroform is, in my opinion, the only true anæsthetic we have. If you know how to give it, and especially combined with oxygen, I think it is the safest thing we have. Even though you use it with a closed inhaler, you get constantly a fresh supply of oxygen, which overcomes entirely any effect of the carbonic acid gas. Furthermore, you can positively control the amount of anæsthetic that you give your patient. You can regulate it to a very small quantity, or you can increase it until you give a very powerful dose, or you can withdraw it immediately and give oxygen alone if it seems necessary or desirable. One of the points that Dr. Bingham made this morning was in regard to the time in which a patient could be narcotized, which is a point of considerable importance. I have made an analysis of the last 100 cases in which I have employed oxygenated chloroform, and while some cases take longer than others, the average for 100 cases is exactly four minutes, in which complete narcosis can be induced and afterward maintained; and this can be done with perfect safety and without suffocation or discomfort to the patient. The actual quantity of chloroform administered—that is, administered and wasted, because you waste a good deal of it, is a trifle over three drachms, which will show you the very small proportion of chloroform that is actually absorbed in the system.

DR. TERRY: What about the time of the operation, Doctor?

VICE-PRESIDENT HAINES: The length of the operations, of course, vary very greatly. The average length of time in 100 cases, as I have tabulated them, was a trifle over thirty-six minutes. That includes all sorts of operations, hysterectomies, appendectomies, operations on the kidney, etc., etc., severe, light and otherwise. I am not prepared to give you just the facts in regard to the effects of this agent that I had intended, and as I hope to do at some future meeting of the Society when I have more time to prepare it. I do not know that I have anything more to add at this time. (Applause.)

DR. SHERWOOD: *Mr. President*, may I ask if you use pure oxygen, or oxygen combined with a certain proportion of nitrous oxide.

VICE-PRESIDENT HAINES: I formerly used what I supposed was pure oxygen gas, but I found upon writing to the chemist that he was not giving me pure oxygen. That was about two years ago. Since that time I have insisted upon getting the pure oxygen gas, that is, that which comes to us marked as chemically pure oxygen, and you can very readily detect when it is not pure. It will turn your chloroform a slightly milky color. If your oxygen is old or decomposed it will immediately, or within two or three minutes, begin to shade off the chloroform a little bit milky, and when it is in that condition I discard it immediately. The chemically pure oxygen is the thing to use, in my judgment.

DR. BUCHANAN: The reason I ask you that, Mr. President, is that Northrup, of Philadelphia—and I believe we are indebted to him for the discovery of chloroform and oxygen, or the first use of it—claims that pure oxygen produces too rapid combustion in the lungs, and consequently an excess of carbon dioxide forming in the lungs, and that you get a condition of shock after anæsthetizing a patient for a time, and he claims that oxygen mixed with nitrous oxide, which is an anæsthetic itself, does away with that. I have never seen myself any of this so-called shock that Northrup speaks of, and I have always used the pure oxygen. I would like to ask you also if you have had any difficulty in using this chloroform and oxygen, in anæsthetizing what anæsthetists term "alcoholics."

VICE-PRESIDENT HAINES: I have had comparatively little experience with alcoholic subjects. Occasionally a large and powerful man will give you a little trouble and I have had a few cases that were addicted to alcohol that have given me some trouble. You have to crowd it a little, but that you can easily do by putting in a little more chloroform and turning in a little more oxygen. It is just as safe to crowd oxygenated chloroform as it is to crowd ether. I have never seen any effects such as Dr. Northrop attributes to the use of it. I have never seen any unpleasant effects in any way from the oxygen. We have never lost a case at the hospital and I have never lost a case under chloroform and oxygen in private practice. I think Dr. Bingham is entitled to close the discussion of his paper.

DR. BINGHAM: *Mr. President*, in reply to the theory that it would be dangerous to employ nitrous oxide in anæmic cases, I would fully agree with that, if it were not that nitrous oxide forms merely a mechanical combination and has no toxic action whatever. The combination with the blood is very feeble and is at any time broken up by giving the patient a proper supply of oxygen. I do not intend to show the superiority of ether over chloroform as an anæsthetic, but merely to demonstrate what I consider the best and most up-to-date method of administering ether. I have used the closed inhaler in preference to the open one. I believe that with a proper knowledge of the instrument cyanosis and asphyxiation are absent. There is no reason why the patient should not receive the proper supply of air.



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## TREATMENT OF CHRONIC ULCERS OF THE LEG.

A. R. GRANT, M. D.,
UTICA.

Varicose veins are the main predisposing cause of leg ulcers and especially chronic ulcers of the leg, the exciting causes being any bruise or wound. Syphilis, eczema and circulatory troubles are indirect causes and their appropriate constitutional remedies must be added to the local treatment when they exist.

If patients did not stipulate that they must be cured while attending to their regular duties that cure would be easy, for the venous return in the superficial tissues of the leg is slow and the upright position increases enormously the congestion and consequent poor nutrition.

To heal these chronic ulcers the surgeon should, at first, personally direct the treatment from day to day until activity in healing is shown, when the intervals may be lengthened to two or three days.

In beginning the treatment of an old leg ulcer the surrounding skin is cleansed with green soap and warm water, and dried. A ten per cent. solution of cocaine is then applied with a pledget of cotton to the ulcerated area for five minutes, after which all necrotic tissue is curetted with a sharp spoon, down to healthy pink tissue.

Pure carbolic acid, crystal, is then applied to the floor thus bared and left long enough to whiten, say one minute, then being neutralized with absolute alcohol.

The round, smooth-raised edge, sometimes called the "callous edge," is then cauterized throughout its whole circumference with a pacquelin cautery.

The wound is now ready for a coating of compound stearate of zinc powder, which is also rubbed into the edges of the ulcer throughout its whole circumference and for at least an inch on the sound

skin outside, the result of which is that the irritating discharge does not attack healthy and newly-formed skin.

The whole area is now covered with a square layer of sterile gauze held in place by three or four transverse strips of Z. O. rubber adhesive plaster.

A two-inch gauze roller bandage is now applied from ankle to knee, and most important of all, a rubber, elastic, webbed bandage, two and one-half inches wide by three or four yards in length from toes to knee or from ankle to knee, according to whether there are enlarged veins on dorsum of foot.

I have long since discarded the Martin rubber bandage, the elastic stocking and flannel rollers, all of which have been recommended for this purpose. The daily subsequent treatment is important and consists in removing dressings and wiping away discharges, taking care not to injure the newly-formed granulation tissue at the ulcer's edge. The powder, gauze strips and bandages are then applied as before. The directions to the patient are to remove the elastic bandage only on retiring, reapplying before rising in the morning.

If the ulcer is slow to granulate the above stimulating treatment is repeated and the dry dressings continued as before.

It has been my custom to make a rough, free-hand tracing of the contour and size of the ulcer from day to day, for it is by this means that the real progress of healing may be best shown.

The results have been uniformly successful even in the oldest cases, the customary pain being relieved after the first or second treatment.

Relapses are very rare and easily controlled, but the elastic bandage is worn for several weeks after the open wound is completely healed. (Applause.)

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## DISCUSSION.

DR. WRIGHT: I would like to ask the author of the paper if he gives no internal medication, but depends exclusively upon the local applications.

DR. GRANT: In answer to that query, if there is a valvular lesion of the heart making the circulation in the extremities poor, such condition is treated by the appropriate remedy. Any œdematous condition is treated, but the condition is looked upon by me as largely a surgical one, surgical measures being necessary to complete the healing of the old chronic condition.

DR. WRIGHT: The reason I asked you whether constitutional treatment was given, was because many years ago in dispensary practice I met with very excellent success with these old chronic ulcers by using internal remedies, and, of course, mechanical appliances wherever a bandage was needed, but without any local application except for cleanliness.

DR. MOFFAT: I think we all recognize the fact that not infrequently there is a uricacidemia underlying these chronic ulcers; it is exclusivism to think of them only as local troubles. I cured a case of an ulcer of about twenty years' standing, and was very proud for a day or two, but then she developed urticaria all over her chest which persisted until the ulcer broke out again; after awhile I think, the ulcer was cured without local applications. I applied resinol in that case, and I have been very careful since not to use the zinc oxide or resinol on any sore without being sure of my constitutional treatment.



DR. TERRY: I think all of the surgeons who have been working over this difficulty for years have found trouble in healing ulcerations of the leg. I know I have. I think it is truly a surgical matter. I do not think it is a case for the indicated remedy. I think that the description here given of this treatment is the best I have ever heard described. I think I might suggest, however, that in a varicose condition, the breaking down of these vessels into an ulceration might be given some attention, constitutionally as well. It has been noticed that in chronic hemorrhoidal difficulties a varicose condition frequently occurs in various parts of the body, the legs and elsewhere, and therefore, in line with that thought, I should look for a causative factor, possibly, in the rectum, because we have found out that by re-fortifying the circulation, removing the diseased tissues of the rectum, the circulation has been stimulated and fortified and the whole body improved. In the 1,000 cases that Dr. Pratt reported a number of years ago, of the American operation, he showed that 365 cases of stomach difficulty were relieved by that operative procedure. I have within two weeks operated in the case of an old lady without valvular disease whose pulse ranged from twenty-seven to thirty-six. She has had two nurses and lived with a hypodermic syringe strung up on the wall, ready to be injected at any moment for her often sudden collapsed condition, due to her irregularity of the pulse, dizziness, poor circulation. Having failed in remedies, tonics, spinal treatments by counter irritants and electricity, I could see but one thing more to do: excise the rectum to get the stimulant I wanted. This was done, using the American operation. Her pulse the following day and to-day ranges from sixty-six to sixty-eight, which, I think, is a most remarkable result, as it shows the fortifying influence and the stimulating results succeeding an operation, the taking away of diseased tissue located at about the end of the spine.

W. M. L. FISKE, of Brooklyn: *Mr. Chairman*, if this discussion is over I want simply to give a little experience. I am getting to be an old man, and as Brother Terry has heard what he regards the finest description of the treatment of an ulcer, I will give him the simplest. Forty years ago I was an interne at the Blackwell's Island Hospital and had charge of the ulcer ward under Dr. Louis A. Sayre. They were a pretty tough lot of subjects that we had up there, and the treatment was simply to strap the ulcers with ordinary diachylon surgical plaster, of which the ZO plaster now takes the place. The

theory was simply to keep the granulations down, or if it was a depressed ulcer, to bring the granulations up, and the everted edge of the ulcer was brought down so that the new skin would form along the line of the surface of the ulcer. These strips of plaster were put on just the same as you would clapboard a house, beginning from below, and keeping them on until the suppurative process softened the straps and the discharge oozed out, and then a new plaster was put on. This used to be all the treatment given in the ward for those chronic ulcers and with wonderful success, with the exception of the constitutional treatment, to build up the patient, as they were all of course from the poorest class, in the charity hospital there, and all required tonic treatment, and were given arsenic or iron. This local treatment I have followed out in my private practice ever since, rarely ever failing to make a cure.

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## RESECTION OF THE METATARSO-PHALANGEAL JOINT.

DEWITT G. WILCOX, M. D.,
BUFFALO.

*Mr. President and Fellow Members:* I have but a short paper to present to this Bureau, because it deals with a very small part of the human anatomy, but, nevertheless, it is a painful subject, as it is relative to bunions.

The prevalence and the great persistence of this seemingly insignificant affection is out of all proportion to the attention which it receives at the hands of the profession.

In speaking of bunions, I have reference to an acute or chronic bursitis of the metatarso-phalangeal joint of the great toe. A bursa, in plain language, is a washer placed over such joints as are exposed to much external pressure or friction. They are fibrous sacks enclosing endo-thelial cells, not unlike those found in the pleura or peritoneum. Nature originally placed over a number of the larger joints such washers, and in adult life, as artificial pressure called for protection, has, as I may say, made up to special order, additional bursæ. The bursa over the joint of the great toe is not there at birth but becomes supplied later in life. The causes of bursitis are numerous, chief of which are injuries, pressure from shoes, gouty diatheses and rheumatoid arthritis.

By far the greater majority of bunions arise from improperly fitting foot gear, especially those which tend to bind the toes together, such as pointed-toed shoes. When the foot rests naturally upon the ground, there is or should be, a slight distance between the great



toe and its next fellow, which in fact, makes the great toe point inward and away from its fellow, instead of outward and towards it. But with the ordinary shoe, the crowding of the great toe outward, binding it close to its fellow, must of necessity give greater prominence to the metatarso-phalangeal articulation. Continued pressure upon this point soon leads to inflammation, from that to cell proliferation, thickening of the fibrous capsule and over activity of the endothelial cells, resulting in a fluid and later pus. The process may go no further than inflammation of the capsule, but that inflammation may extend to the synovial structures of the joint and the periosteum, resulting in thickening of the periosteum and later of the bone itself.

We then have a bunion characterized by a large, bunchy joint, red, extremely sensitive, giving pain upon the least pressure. In this state it is quite prone to set up a cellulitis, especially if infected in the least, through an incision or puncture. It is due to such causes that we get those dangerous inflammations from the irritation of bunions, which result in rapidly progressing cellulitis, gangrene and septicæmia. The condition is likely to be made worse if there is a rheumatic or gouty tendency present.

The purpose of my paper is to deal only with the ultra-serious phase of the disease, when the joint has become greatly enlarged and exceedingly painful, resulting in a more or less crippling of the patient or at least periodic attacks of pain, which render active life a burden. Patients so affected have usually availed themselves of all the known palliative remedies, and in the majority of instances, without much relief. The applications of plasters, blisters, cushions and appliances for keeping the toe in a straight line with the metatarsal bone gave but indifferent relief. A number of these extreme cases have come into my hands in the last few years and I have resorted to a variety of procedures for relief, but only until I adopted the radical operation, which I am about to mention, have I found relief for the sufferers.

About six years ago, a young woman who was almost a cripple from this affection, came to me, willing to undergo anything that would promise relief. I tried the plan of making a complete resection of the end of the metatarsal bone. The wound healed quickly and she was able to be out in two weeks. I first operated upon one foot only and in a few months she returned with the request that I make a similar operation upon the other foot, as she had obtained perfect relief from the first operation.

My method of operating, which I have improved slightly upon the first, is as follows: After rendering the foot as nearly aseptic as possible, an incision about two inches long is made on the inner surface of the foot parallel to and just above the Adductor Policis tendon, which is here quite prominent; or, in other words, parallel to the plantar surface of the foot and about midway between the dorsal and plantar surfaces, bringing the middle of the incision just above the joint, exercising care not to incise the Adductor Policis tendon. This incision is carried down to the periosteum, the blood

vessels are secured, as the Esmarch bandage is not used. I deem it better to tie the vessels as I proceed rather than compress them with a rubber bandage and perhaps have considerable oozing after the wound is closed up.

Next, the periosteum is incised over the joint and along the side of the metatarsal bone for a distance of about one inch from its distal end. With a small periosteal knife, I separate the periosteum from the metatarsal bone about its circumference, dissecting it loose down to the end of the bone. An aneurism needle, curved to correspond with the curvature of the bone is then swept around it, carrying a silk ligature to which is attached a wire saw. This, in turn, is drawn beneath the bone and after placing the saw in the proper position, which is just back of the enlarged head, the bone is sawed off and the head dissected free from the joint connection with the phalanx. All bleeding is then secured absolutely, the wound well washed out with bi-chloride solution and closed. A light sole splint is applied to the foot, to aid in keeping the toe in a straight line with the metatarsal bone. No plaster of paris used. The results have been perfectly satisfactory. No suppuration in any case, no weak foot, no crippled toes.

Since then I have operated upon some twenty or more cases and in every one have I obtained the most gratifying result. All of my patients have been active men and women whose occupation demands their being upon their feet a great portion of the time, but in none has there been the slightest complaint of a weak foot. (Applause.)

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# THE SURGICAL TREATMENT OF DYSMENORRHŒA.

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Dysmenorrhœa is uterine or tubal, according as one or the other of these organs is the seat of obstruction to the discharge of menstrual blood. Ovarian dysmenorrhœa does not exist, for in the human female the ovarian function is continuous, and therefore any pain caused by ovulation is not confined to the menstrual period, but may occur independently of it, and at any time. With the treatment of this we are not concerned at present, for while the condition may require operative interference, we are not dealing with painful menstruation, but painful ovulation, which is not a factor in dysmenorrhœa.

For the better discussion of our subject, I would limit dysmenorrhœa to the pain felt immediately before, and during the flow; that



is, to pain connected with the menstrual function, and dependent upon some error in the functional activity of the organs concerned with menstruation. Among these we cannot include the ovaries, or the process of ovulation.

The possibility of neurotic dysmenorrhœa is recognized, that is, painful menstruation dependent upon derangements of the nervous system, without local pathology; a condition that disappears with the restoration of nervous equilibrium. But such cases do not come within the scope of surgery. The more closely we examine the etiology, and make ourselves familiar with the pathological history of dysmenorrhœa, the fewer cases having a purely nervous origin will we find to treat.

Painful menstruation is always caused by an inability of the uterus to complete the function that it has begun to perform. What is that function? The periodical flow of blood from the uterus peculiar to the human female, is under the control of a nerve centre, and probably not at all caused by ovulation, or any process that may take place in the Fallopian tubes connected with that function. That changes in these organs may be associated with menstruation, is beyond question, but that they stand in the relation of cause and effect, has not been established.

Briefly presented, the case stands thus. Ovulation with woman is a continuous process, observing no periodicity, and extending over a longer period than is covered by menstrual life. Removal of the ovaries does not of necessity arrest menstruation, and has been found to take place before the establishment of the function.

While it is probable that the Fallopian tubes sympathize in the menstrual process, and participate in the local condition that determines the flow of blood, there is nothing to show that they cause the monthly flux, and their removal is not of necessity followed by the menopause, unless possibly the menstrual nerve is included in the amputation. That menstruation is most intimately associated with the reproduction of the species, receives confirmation from every step of impregnation, and of intra-uterine life. I am not aware of any case being recorded of a woman having borne children who had not menstruated, but such is quite conceivable upon the theory that menstruation is an aborted attempt of nature to provide a resting place for the fœtus. Menstruation and fertility go hand in hand. Ovulation may take place, but if the changes in the uterine mucosa which are concerned in the formation of a decidual membrane are not set in motion, even though impregnation has occurred, development of the ovum proceeds no further than the very earliest stages; it cannot develop without the assistance of the mucosa.

What, then, is menstruation? What is this process, and under what influence is the menstrual cycle induced?

Repeated investigations have shown that menstruation is accompanied with well marked changes in the uterus, especially the endometrium. During the week or ten days preceding menstruation the endometrium becomes infiltrated, the capillaries enlarged, and the

lymphatics dilated. The round cells in the interglandular tissue multiply, and the mucous membrane becomes infiltrated with leucocytes. The uterine glands also become active, as shown by increase in size, and augmented secretion. The entire process represents the formation of the "decidua menstrualis." The uterus and cervix are enlarged, soft and flabby. The cervical canal dilates, its glands are enlarged, and secrete an unusual quantity of mucus. With this preparation the flow of blood arises from the greatly dilated capillaries, not by the bursting of their walls, but through diapedesis, which seems to be caused by contraction of the uterus and tubes. This process is not accompanied by extensive destruction of the mucosa, but there is a considerable fatty degeneration of the epithelial cells composing the superficial layer. The blood, which is mixed with mucus from the uterus and cervix, coagulates slowly because of the admixture of the secretion from the vagina.

In the folding up of this period, the useless cells are cast off, and the epithelium regenerates. Some of the epithelial cells that have enlarged in the lumen of the uterine glands are absorbed. The nuclei of the leucocytes divide, and the stroma, glands, and mucosa assume the normal pre-menstrual state. Excepting in some instances, and these under the influence of local disease, the decidual membrane which is reformed with each menstrual cycle, is not thrown off as such, but involutes, the cells of which it is composed being taken up by the uterine glands, and disposed of by a process of phagocytosis. The object for this entire process, including the formation of the decidua menstrualis, is defeated when there is no impregnated ovum within the uterus, and the organ returns to its normal condition until such time, as under the influence of the menstrual centers, it again prepares itself for the function of fœtal nourishment.

A careful consideration of the process of menstruation, beginning with the capillary congestion of the uterine mucosa, and ending with the disposal of new cells, and regeneration of epithelium, suggests explanations for the pain which accompanies the function. Some irregularity may attend the cellular changes of which the decidual membrane is rendered more active. Any process relating to congestion and swelling, may be arrested before the completion of its folding up, and hence the physiological thickening becomes a permanent pathological factor. In the uterus this oft repeated abortive attempt at reconstruction, the necessity, probably not contemplated in nature's reproductive scheme, of removing, and disposing of new cell formations which each menstruation represents, may well be looked upon with suspicion, as fruitful in causing such lasting changes in the uterine mucosa, as interfere with diapedesis, rarely rhexis, by means of which the blood leaves the capillaries; and later interrupts the free passage of blood from the uterine cavity. In other words, the process of thickening may affect the capillary walls, and the thickening of the mucosa offers obstacles to the free passage of blood through the uterine os.

That similar processes may invade the Fallopian tubes, or spread



from the uterus, and there give rise to the same pathology we have found in the uterus, is within reasonable possibilities. Hence we have dysmenorrhœa preceding by twelve or twenty-four hours the menstrual flow, but this cannot be classed with uterine pains, being more of the nature of colic referred to the ovarian region. Such pain is not due to the obstructed passage of an ovum, but to changes in the mucosum of the tube, similar to those that have taken place in the uterus.

To derangement of the uterine mucosa, dependent upon aborted attempts of the uterus to perform its functions of nourishing a fœtus, I think we may attribute the greater number of cases of dysmenorrhœa, for they are obstructive, and this obstruction is caused in the majority of cases by swelling, or some unhealthy state of the lining of the uterus.

Following the theory of menstruation which we have advocated, it seems probable that in the natural state, the human female should not menstruate. The uterus, recovering from a previous conception, holds the impregnated ovum, and forthwith prepares its decidual membrane for the function of fœtal nourishment. The process, therefore, of folding up of this membrane is not reached, and the evidences of such folding up, menstrual flow, are not observed. But from one cause or another, nervous, social, and what not, natural laws are broken, and there are repeated attempts at the formation of a decidual membrane under the cyclical control of the reproductive centers. Thus menstruation takes place.

Some women pass through life without a menstrual history, that is, without suffering, while others make up the large proportion of the patients who have only a small part of each month in which they are free from suffering, either local or reflex.

I am skeptical as to the part that uterine displacements bear in the etiology of dysmenorrhœa. Of course, if the cervical canal is closed by being bent upon itself, obstructive dysmenorrhœa must result, but is such a mechanical condition usual in misplacements? I think not. It has been demonstrated that only a very small opening is necessary for the menstrual blood to pass through the os, for the flow comes in drops; and it has also been demonstrated that the os, being an erectile organ, dilates, and the cervical canal under the same influences straightens sufficiently to overcome ordinary mechanical obstructions. It thus seems probable, that under the stimulus of the menstrual nerve, the cervical canal will accommodate itself to the flow of blood, if the obstruction is limited to the muscular tissues of the organ.

It is a familiar fact, that a large number of uterine displacements exist without awaredness on the part of the patient, and my experience leads me to attribute the dysmenorrhœa associated with misplacements of the uterus, to, primarily, some other cause, acting in connection with the displacement. While we cannot hope to cure the dysmenorrhœa without relieving the displacement, that acting as a mechanical irritant, I believe we err if we regard the latter as

more than a symptom; we certainly will be far of the mark if we treat it as the cause. The classic belief that endometritis, and metritis are due to retroflexion, or anteflexion of the uterus, does not stand the test of modern exactness in clinical observation. It is reasoning from the wrong end of the line. Rather the misplacement is caused by the enlarged and heavy fundus, and the deflexion of the cervical canal is only a mechanical result.

Upon the belief that the local cause of dysmenorrhœa is some derangement in the metabolism of the uterine mucosa, and my reading of the menstrual cycle confirms such a belief, the surgical treatment of painful menstruation concerns itself chiefly with the endometrium, and its restoration to health.

I think it is not too much to say, that the cure of dysmenorrhœa cannot be accomplished while any degree of endometritis exists, and that when the latter is removed, the most important step has been taken towards the removal of the painful symptoms. The use of local medication, that is, direct applications to the uterine mucosa, I do not place much reliance upon. To reduce the size of the uterus, the glycerine tampon, icthyol, boroglyceride, hydrastis, sanguinaria, iodine, and carbolic acid, will, according to the indications, accomplish much. But no application should be relied upon for the cure of the diseased endometrium. Thorough curettement, through a thoroughly dilated os, is necessary to effect a cure. The mucosa, as we have seen, has become swollen and congested, its capillaries increased in size and number, and their walls thickened. The hypertrophied membrane must be removed, and nature given an opportunity to form another, after so many abortive attempts to utilize this one.

The operation of curettement is in itself of no magnitude, but thoroughness, and exactness, make for much in its success. No operation in gynæcology requires more attention to aseptic technique than does this one. The uterus, after removing the mucosa, is very susceptible to the absorption of septic organisms; this applies with especial force to the os, and cervical canal, and the preliminary divulsion of this segment should be attended with every possible precaution to insure against infection. The divulsion should be slow, and steady, for if rapid, and spasmodic, not only the superficial structures are lacerated, but the deeper muscular fibers, as well. I have seen an os prepared for curettement, resemble a recent puerperal laceration, a condition entirely unnecessary, unwarranted, and favorable to the development of infectious inflammation, and it is probable that many cases of septic metritis owe their origin to absorption at this point. Septic metritis is not strictly a part of the present discussion, but it may in results, and lasting effects, produce changes in the endometrium, that lead to dysmenorrhœa.

During curettement the uterus should be firmly supported, the curette acting against the volsellum used for that purpose. The frequent withdrawal, and reintroduction of the curette is to be deprecated. It is rarely necessary to remove the curette—save to change the instrument—until the entire mucosa has been gone over, and we are ready to wash out the debris. My own method is, curette



the fundus, including the cornua. The product of this is preserved in a separate receptacle for examination. The instrument is then changed for one, the blade of which is at a more acute angle with the shaft, and with this, the walls of the cavity are scraped down. The tissue thus removed is preserved in a second bottle. By this procedure the products of the two segments of the uterus are examined separately. We are thus able to diagnose with more accuracy the seat of degeneration, and applying this technique to curettement in general, we can locate malignant changes. The knowledge thus gained will aid in our prognosis of the case, and possibly decide for, or against, a radical operation.

After the uterus is thoroughly irrigated with salt solution, sometimes electrozone, I swab out the cavity with strips of iodoform gauze, until these come away clean of shreds. By this method pieces of tissue are removed that would not be caught in the irrigating stream. Formerly I swabbed the uterine cavity with iodine, but this I consider unnecessary. It serves no therapeutic purpose, and if the operation has been aseptic, has no other effect than to coagulate the exudate from the denuded surfaces. Where drainage is sought, the use of iodine cannot but be harmful, for the coating which it forms prevents free discharge from the uterine surfaces. I drain the uterus with a single strip of lightly placed iodoform gauze, carried to fundus. This serves a double purpose. It holds the os open, and therefore drains the cavity, and at the same time keeps the walls of the cavity separated, and thus prevents the formation of pockets, and dead spaces in the contracting tissues. There should be no discharge on this piece of packing, when it is removed. Its presence indicates to me that my technique has been at fault. As a final step, the uterus is lifted into position and the vagina packed with iodoform gauze. This is a most essential part of the technique, for upon it depends the correction of any displacement of the uterus, and also the restoration of the uterine and pelvic circulation, which are always more or less at fault when there is a displaced uterus. I rarely find it necessary to renew the uterine drainage after its removal at the end of forty-eight hours, but the vaginal packing is continued for at least two weeks.

I have seen a few cases of dysmenorrhœa that owed their cure to the repair of a lacerated cervix, but I look upon this operation, not as curative in itself, but as contributing to the healthy restoration of the mucous lining of the uterus.

As we cannot regard misplacements of the uterus as a cause of dysmenorrhœa, their cure, *per se*, occupies a secondary position in the cure of painful menstruation, but to render the results of curettement more effective, it may be necessary to adopt some mechanical measures looking to that end. The degree of functional derangement of the uterus caused by displacement, depends, not upon extent of the displacement, but upon the position this holds in relation to the pelvic straits. That is to say, the uterus may deviate far from its normal axis, the fundus may rest upon the rectum, or the bladder, according as the organ is retro or anteflexed, without interfering with

the uterine function, or giving rise to sufficient discomfort for the patient to seek relief. If, on the other hand, the uterus as a whole, or in part, occupies a position below the superior strait of the pelvis, not only is the circulation so interfered with that the endometrium suffers congestion, but the natural katabolism of the uterus, which is a part of the menstrual cycle, the destructive metabolism, as well as the katabolic or reconstructive processes, are for the same reason interfered with. In such instances curettement must be associated with permanent reposition of the uterus.

Of the methods that I have employed to hold the uterus in position, I favor ventrofixation as being of more general application, and productive of more permanent benefit, than any other operation. Alexander's operation has, in my hands, not met with the success, so far as holding the uterus in position is concerned, that I had anticipated from the reports of other surgeons. While I have had no special difficulty in finding the round ligament, theoretically I have not been surprised at the results, for I can arrive at no reason for believing that a stretched and weakened ligament can be permanently strengthened, and permanently tightened, by shortening. Naturally the ligament will continue to stretch, and thus become more and more attenuated. At all events, even though the round ligament has been well fastened, and the uterus placed in position, I have found the organ to eventually assume the position of displacement for which the operation was done. I may have been unfortunate; I can but record my experience, and from it, deduct my plan of treatment.

The vaginal operations for uterine displacements, advocated principally by the German School of Surgeons, seem to me lacking in the requirements of true surgical procedures. They endeavor to supply from below, structures which nature has dictated should be constructed from above, and while repair of the floor of the pelvis should always form a part of any operation for uterine displacement, this alone, or constricting operations on the vagina, cannot hold the displaced uterus in position. Such operations are surgical pyrotechnics, and serve to exhibit the manipulative skill of the operator, rather than to benefit the patient.



# REPORT

OF THE

BUREAU OF OBSTETRICS.



## RUPTURE OF THE FALLOPIAN TUBE AND ARTERY AT FULL TERM AND IMMEDIATELY PRECEDING "LABOR."

F. P. WARNER, M. D.,
CANANDAIGUA.

Spontaneous rupture of the ovarian tube and artery is of rare occurrence, and medical works seldom speak of this accident. Nevertheless, having had two cases of such during the past four years, the subject is of such importance as to merit a passing notice.

The etiology of this condition in the two above-named cases being so widely different, there can be no definite cause named unless it be a relaxed or brittle condition of the tube and artery.

One case occurred in a young lady of twenty-three years, of a relaxed and phlegmatic temperament in the non-pregnant state; and the other, of which I shall speak, was of a nervous temperament and of small stature but of great endurance. The latter suffered from a varicose condition of the veins of the legs, and the rupture occurred at the second labor in a lady of thirty-five years.

The exciting cause of the former case was from a sudden fright; of the latter case, it came on suddenly while the lady was sitting in a chair at the dinner table. She was at full term and labor was expected to come on at any time.

The history of the case will give an idea of the condition. On July 22nd I was called to see the patient who was said to be suffering from an attack of cholera morbus. Found her lying on the floor

and suffering from intermittent pains in the abdomen. She had vomited quite a good deal but no purging. She was pulseless at the wrists and was covered with a cold, clammy sweat, and all the extremities icy cold.

Countenance was pinched and collapsed, and patient was suffering from all the symptoms of a profound shock. Stimulants and heart tonics were given vigorously and persistently for several hours before any signs of reaction came on. The patient was first seen at 5 o'clock p. m. Reaction began to come on about midnight, when a slightly bloody discharge from the vagina appeared. This increased with such persistency that "placenta prævia" was suspected. An examination was made expecting to find such a condition. The os was open to about the size of the little finger, so a diagnosis of placenta prævia was eliminated as the child was lying in utero in the normal position and placenta not advancing. The patient kept on flowing gradually for a couple of hours longer, and symptoms from loss of blood becoming more and more threatening, delivery was considered advisable. The os was dilated by means of finger and dilator, instruments slipped on and delivery accomplished at once.

When the fœtus was taken away the hæmorrhage became more profuse, the blood spurting off from the bed on the floor in considerable quantities. The hand was then introduced into the uterus and the placenta removed without any difficulty, still the flowing did not cease. Remedies as best indicated were prescribed internally, and ergotole and atropine injected beneath the skin, and the uterus forced to contract from pressure without.

While the uterus seemed to be firmly contracted, yet the hæmorrhage kept on throughout the night and patient died at four o'clock a. m., exsanguinated.

Post mortem revealed the left ovarian tube ruptured between ovary and uterus, about one-fourth distance from uterus, and quantities of clotted blood in abdominal cavity. The blood in abdominal cavity accounted for the intense shock. This rupture of tube must in turn have set up the hæmorrhage from uterus.

From the foregoing history we can give the symptoms of rupture of ovarian tube at full term of pregnancy as having all the symptoms of shock. Coldness of whole body, the flesh all over felt icy cold, pulseless at wrist, body covered with cold, clammy sweat, vomiting, pain in abdomen located at the right or left of median line, soon followed by slight hæmorrhage which increases in intensity.

The persistency of the shock symptoms, the slow reaction, after the use of all known heart remedies, will help to make the diagnosis of this serious condition.

Having made the diagnosis, what is to be done? In giving the history of the case above, the treatment is outlined in full as to this particular case. These symptoms all being so violent, one thing after another coming on so rapidly, and not having at hand the experience of others, and the shock being so violent, this case was given up; feeling that all had been done that was possible.



Were we to meet another like case the following course would be taken: Ergotole and atropine would be given subcutaneously to check the hæmorrhage and to bring on reaction. Camphor, verat. alb., camphorated oil and stimulants per mouth and salt solution per rectum. As soon as sufficient reaction was established to permit an anæsthetic, ether would be administered and the abdomen opened and the tube tied off and removed with ovary, and delivery accomplished, either by the cæsarean section or by the natural outlet. The percentage of recoveries might not be large, as we would have a serious condition to start with, yet this treatment as outlined is the only course one could pursue and would offer a good prospect of saving the patient.

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## UREMIC ECLAMPSIA: SOME FACTS AND OBSERVATIONS.

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ROCHESTER.

Purdy claims the general cause of eclampsia lies in the failure of the kidneys to excrete the urine in part or whole, and that the urine, or its primary elements, acts as direct toxins upon the organism, evoking symptoms termed uremic.

It is not my intention to set forth in this paper the causes of eclampsia or to discuss the already advanced theories concerning its origin; but rather to present, in a clinical way, cases observed by me during my service as house physician at the Rochester Homœopathic Hospital.

No class of disease in the domain of medicine presents more alarming manifestations or terrifying symptoms than those due to uremic poisoning. Especially is this true of the eclampsia of parturient women.

This dreaded disease was at first happily considered to be of rare occurrence, but recent investigations tell us only too plainly that puerperal eclampsia is much more frequent than was formerly supposed; in fact, so much more so that every practitioner is almost certain to meet with it sooner or later during his career. Kaltenback estimated that it was found once in 500 pregnancies; Auvard, as occurring three times in one thousand cases, while the statistics of the Philadelphia Board of Health (1868-1873) show the occurrence of eclampsia once in every 170 labors.

The laity, as a rule, look upon all cases of labor as being perfectly natural and normal and can and will not overlook a fatal issue. This fact is, then, of momentous import to the young physician whose

reputation is yet to be established, as the loss of a case may ruin his prospects in the community in which he resides. It is, therefore, of the utmost importance to recognize early the symptoms of uremic poisoning and to employ the best known methods to bring about its proper elimination. The symptoms of the pre-eclamptic state should be especially looked for in primipara. On account of the greater intra-abdominal pressure, longer labor and the more extreme nervous excitation first pregnancies are more predisposed to convulsive seizures.

In three cases coming under my observation, and which I now cite, all occurred in primipara and are especially interesting on account of the severity of the symptoms. One occurred during pregnancy; one during labor, and the other after its termination. Two were admitted to the hospital in a state of coma, with a history of no previous medical attention.

Case No. 1. Age 20. Nativity, United States. Gestation of the eighth month. Admitted September 8th, 1901, at 6 p. m. Unconscious. Temperature, 104; pulse, 140; respiration, 38. Two days before was taken with convulsions which occurred at frequent intervals followed by coma. The doctor first called was unable to diagnose her case, but prescribed for her, nevertheless. She soon grew so alarmingly worse that another physician was sent for who immediately recognized her condition and brought her to the hospital. As soon as admitted she was catheterized. Six ounces of urine were drawn, densely loaded with albumin and showed sp. gr. 1010, urea .002. Patient had numerous convulsive seizures, lasting three minutes, until 12 p. m., when she was forcibly delivered (podalic version) of a dead child. Verat. Vir. $\theta$, drop doses, prescribed every hour. She had, during the night, sodium brom. grs. xx., chloral, grs. xv., pilocarpin, gr. 1-10, (hypo), strych. 1-25. A hot pack was used four times. Poland water, oz. vi. and milk, oz. ii. were ordered every hour during the night when able to swallow. Saline enemata were given (one pint) every four hours. September 9th, 6 a. m., temperature, 103 3-5; pulse, 135; respiration, 36. In profound stupor most of day, only aroused once for a moment, when she recognized her mother. No return of convulsions. Urine drawn oz. vii., making oz. xiii. for the twenty-four hours. Foxglove poultices ordered over region of the kidneys. In afternoon became greatly distended. Salts and glycerine enemata given with good result of fæces and gas. Verat. Vir. $\theta$ and salines continued. September 10th, temperature, 99 4-5; respiration, 28; pulse, 100. During night convulsions returned. Wildly excited; threw herself out of bed. Conscious of things going on about her this morning, although she does not speak. Urine oz. xv., no change in its pathological constituents. September 11th, 6 a. m., temperature, 102; pulse, 106; respiration, 25. Rational, but crying and moaning. Bromide and chloral again given. Ten a. m., vomiting, stupid and greatly distended; distension not relieved by enemata. Convulsions returned at 11 a. m., followed by stupor, and death resulted at 1 p. m.



Case No. 2. Italian. Age 26. Ninth month of gestation. Admitted December 13th, 1901, in comatose state. Husband stated she had been in excellent health up to present time. In the morning she complained of being dizzy, so he took her out for exercise in the air. While walking she was taken with a convulsion and before he could make arrangements to bring her to the hospital she had three more severe ones. On arrival she was immediately put on obstetrical table. Examination revealed that labor had begun, cervix permitting the introduction of three fingers. During the examination she had two more eclamptic seizures, and it was deemed advisable to hasten delivery. The cervix was soon dilated manually, the forceps were applied and she gave birth to a still-born babe at 4:50 p. m. Free post-partum hæmorrhage followed which was easily controlled by hot sterile water intra-uterine douche. A catheterized sample of urine, previously obtained, gave the following result: Albumin, solid precipitate, sp. gr. 1006; urea, .007. After being put to bed she slowly regained consciousness and complained of a severe headache and pain across the abdomen. Verat. Vir. $\theta$ in three-drop doses ordered q. two hours. She was encouraged to take six ounces of Poland water every hour and was given saline enemata every three hours. During the night she voided fifty-six ounces of urine. Urine showed only a trace of albumin, sp. gr. 1018, urea .016. Improvement rapidly continued, headache and abdominal distress soon disappeared; she never had another convulsion and was discharged in just a week entirely recovered.

It might be well to state that both of these women were private cases, treated by old-school physicians, thus accounting for the same routine treatment—the prescribing of Verat. Vir., and the administration of bromide and chloral and strychnine in the first case.

Case No. 3. Nativity, Irish. Age 24. Eighth-month gestation. Admitted November 15, 1901. History of previous gonorrhœal infection; has profuse non-excoriating discharge. Urinary analysis, sp. gr. 1030; no albumin or sugar; urea .023. Large amount pus corpuscles. Rx. Puls. 3x; carbolic douches B. I. D. December 3d, urine examined, sp. gr. 1008; two lines of albumin; urea .005; no casts; large quantities of pus cells. Amount of urine in twenty-four hours, forty-four ounces. Vaginal discharge less profuse. Complained of pain on micturition. Rx. Mer. Corr. 3x. Poland water ad lib. Diet restricted; less nitrogenous food, more milk. December 10th, less vesical irritation and vaginal discharge. December 14th, another examination of urine showed total amount had increased to seventy ounces in twenty-four hours; sp. gr. 1022; no albumin; urea .035. Apparently in good condition. December 17th, in labor at 11 p. m. December 18th, after being in labor seventeen hours (breech presentation) she delivered a still-born child at 5 p. m. She was taken from the table at 5:45 p. m. and put to bed. At 6:15 began to act strangely; spoke in an incoherent manner of strange objects appearing before her eyes; the muscles of her hands, face and arms twitched and in a few seconds was in general con-

vulsions. During the seizure, which lasted about two minutes, she became greatly cyanosed and her pulse was hardly perceptible. Hypodermics of whisky and digitaline were immediately given and oxygen administered at frequent intervals. In a short time the pulse came up, but it was impossible to arouse her from the coma into which she had fallen. Before a vapor tent could be placed over her she went into another convulsion, less severe than the first. Chloroform was administered during this attack. After the convulsion had subsided an enema consisting of one pint of normal salt solution and one ounce of whisky was given. Pilocarpin ⅛ gr. by hypo. and a hot, wet pack soon produced a free perspiration. Treatment: Aconite 3x. Poland water, oz. vi. q. hr., foxglove poultices applied to lumbar region, whisky when necessary, saline enemata q. three hours. (A catheterized sample of urine after first convulsion showed the presence of a large amount of albumin.) December 18th, patient somewhat out of stupor; recognized doctors and nurses. Temperature, 102; pulse, 128; respiration, 30. Urine, by catheter, for twenty-four hours, six ounces, sp. gr. 1030. Test tube solid with precipitate of albumin. Urea .003. Uric acid crystals, hyaline and granular casts, pus corpuscles and epithelium from bladder and kidneys. Same treatment ordered continued. Diet to consist of four ounces of peptonized milk every two hours. December 19th, decidedly worse, complete suppression of urine, meteoric distension of abdomen. In deep coma. Pulse, 144; irregular and weak; temperature, 100; respiration, 36. Treatment: Bell. discontinued; Rx. cup. ars. 2x and dig. $\theta$ in alternation q. two hours; foxglove poultices to be continuously applied over region of kidneys; milk and Poland water continued. During evening thirty-one ounces of urine were obtained. Heart very weak during night, had to be stimulated often. Distension partially relieved from time to time by salts and glycerine enemata. December 20th, can be aroused at times; still badly distended. Bronchitis developed. Marked œdema of the face, eyelids and ankles. Frequent vomiting of mouthfuls of reddish-brown fluid. Excreted forty ounces of urine in last twelve hours; had an involuntary dejection; cuprum ars. discontinued. Rx. bry. and apis in alternation. General treatment continued. December 21st, temperature, 98; pulse, 104; respiration, 24; great improvement; passed comfortable night; slept seven hours; mind clear; cough better; œdema still present; fetid odor from lochia; distension less marked. Urinary analysis, sp. gr. 1024, albumin about three lines, urea .019. Previous treatment continued, with addition of carbolic douches q. four hours. December 22d, temperature, 101; pulse, 120; respiration, 20; entirely rational, complains of distress in stomach after nourishment, urinated to-day for the first; amount of urine seventy-two ounces (twenty-four hours), œdema less marked. Treatment: Nux substituted for apis; foxglove poultices ordered discontinued. December 23d, improved in every way; temperature, 98; pulse, 80; respiration, 26; œdema gone, cough nearly subsided; only a trace of albumin in urine; liquid peptonoids added to diet. Continued gradually to improve; discharged December 31st, recovered.



Knowing the forcible advent of eclampsia, the severity of its symptoms and the too oft fatal results both to mother and child, it behooves us to be most careful in our observations of pregnant women committed to our charge. Never was the old adage, "an ounce of prevention is worth a pound of cure" more trite than in the handling of this disease; therefore, too much stress cannot be laid upon prophylaxis. The prophylactic treatment consists in keeping the patient in a healthy condition by means of outdoor exercise, wearing of suitable clothing, selection of proper food and regulation of the bowels and excretory organs of the body. A careful examination of urine should be made at least once a month; better still, every two weeks, for which a twenty-four hours' specimen should be insisted upon. The detection of albumin alone is not of any special pathological significance, as it occurs normally in from three to five per cent. of pregnant women and is not found in every case of eclampsia. If, however, there be, in addition, a marked diminution in the excretion of urea and total solids associated with various nervous and gastric disturbances, such as headaches, insomnia, vertigo, sudden blindness, nausea, vomiting, epigastric pain and mental excitement, we recognize a condition of toxæmia and must direct our treatment towards the speedy elimination of the poison, else convulsions may supervene. In suspicious cases showing symptoms of uremic poisoning, when the urine is below 1010 sp. gr.; urea less than one per cent. and the total amount of urine less than three pints per day (twenty-four hours) the patient should be put to bed on exclusive milk diet. Stimulate the emunctories by means of hot packs, hot tub or vapor baths, saline cathartics and the ingestion of large quantities of water. Aconite, bell., cup. ars., merc. corr., nux vom., rhus tox. and bry. are of great value according to the symptoms. If, under treatment, no improvement follows or severe oft-repeated convulsions arise, labor must be brought to an end.

With the development of eclampsia we are brought face to face with a very grave condition, and unless heroic treatment is employed the disease generally progresses to a fatal issue. The general measures adopted by the various schools of medicine do not materially differ in the treatment of puerperal convulsions. Antidotes and eliminative agents are just as important in uremic toxæmia as in other poisons, and should be used by the intelligent physician regardless of creed or dogma. During eclamptic seizures give chloroform. Veratrum Viride, when indicated by tumultuous heart, rapid, strong pulse and high fever, is followed by most gratifying results. It is the sheet anchor of the old school, and much lauded in all their text-books, but they fail to realize, when success follows its administration, that they have prescribed it in accordance with the law of similars. It should be given hypodermically, from five to fifteen drops of the tincture to get the most favorable results. Cuprum ars., 2x, is highly recommended by Goodno and others as a cure for convulsions. In the third case reported not a convulsion returned

after it was given. Not only does it have an effect upon the convulsions, but it also increases the flow of urine.

For the cerebral hyperæmia accompanying eclamptic seizures aconite, bell., hyos., stram., cicuta, gels., and apis are useful as indicated. If we are unable to control the convulsions by the apparently indicated remedy, chloral, bromide of soda or morphine may be tried, but cautiously, as they are apt to lengthen the post-eclamptic coma. When the pulse becomes weak, oxygen, whisky and digitalis are our most valuable stimulants. Strychnine, on account of its irritant action on nerve tissue, is contra-indicated although it is universally prescribed by the old school. Attenuation and elimination of the poison is best accomplished by the administration of large quantities of water by mouth and rectum; by catharsis, venesection and free evaporation from the skin. Active purgation is needed. Epsom salts, croton oil and elaterium are usually soon followed by watery stools. For sweating I believe the hot pack to be the most reliable, as the shock is not so great and better opportunity is given to watch the heart than when the air and tub baths are given. I recall the case of a young girl suffering with eclampsia of Bright's disease who immediately went into a state of coma and died after being put in a hot tub bath, where previously she had borne well a number of hot packs. Pilocarpin, in doses from ⅛ to ¼ gr. (by hypo.) acts well in cases where there are no symptoms of pulmonary œdema. Blood-letting is advocated by many when there is danger of apoplexy from high arterial pressure. Its efficacy is greatly enhanced by infusions of normal salt solution. In my second case the post-partum hæmorrhage was undoubtedly of benefit, especially when replaced by saline enemata. Epistaxis frequently observed in eclamptic women shows that nature is trying to throw off the poison by opening an avenue of escape for the toxic blood. In this connection it should not be forgotten that aconite is an internal bleeder and is worthy of a trial.

Where the urine is greatly diminished and suppression is threatened, such drugs as ars., apis, apocynum and digitalis are to be considered. Dry cupping, followed by hot fomentations, is advised, but nothing exceeds the action of foxglove poultices in promoting diuresis. The good results obtained by a thorough trial of these poultices at the Rochester Homeopathic Hospital led to their appreciation in all cases of renal insufficiency treated there.

When we consider the mortality of puerperal eclampsia—thirty per cent. in mother, fifty per cent. in child—and know that cases recover without any aid whatever, we cannot help but realize how powerless medical science is to combat this virulent and overwhelming disease. Not until its pathology is definitely known can we hope for better results.



# PLACENTA PRÆVIA—UREMIA—GRIPPE. A COMBINATION CASE.

GEORGE R. STEARNS, M. D.,
BUFFALO.

In spite of our boasted progress in the science and art of medicine there occasionally comes under our observation a patient—fortunate, indeed, is it that they are as rare as they are—in whose care every step instituted to stem the progress of disease and to relieve the suffering organism seems absolutely futile and the case goes steadily on to a fatal termination. Such was the result experienced in the case of a Mrs. H., admitted into the hospital on Christmas day last during my term of obstetrical service. The history given on her admission was brief: Age, 35; married; had had five (5) children, the youngest two (2) years of age; previous deliveries had been uneventful, though she had a severe attack of "grippe" during the early months of her last pregnancy, but went to full term, as described; now a little short of seven (7) months pregnant; had been suffering for three or four days past from a severe attack of "grippe" with a temperature ranging from 103½° to 105° and the customary pains and catarrhal conditions generally. During the past two (2) days she had been flowing profusely with some abdominal pains at times.

Examination revealed the fact that it was a case of placenta prævia, the os not yet beginning to dilate; temperature, 104°; respiration 40 to 50, and very much oppressed and labored, though the lungs gave no physical signs of becoming involved. Urinary examination showed the presence of marked albuminuria with numerous granular casts; the urea decreased and the urinary secretion itself diminished in amount. There was no general anasarca; but little œdema about the ankles, none in hands or face. The skin was dry and hot, the pulse full and bounding and 140 per minute.

She was put to bed, given a warm sponge bath, a free saline enema to clear the bowel and a large, hot bi-chloride douche to cleanse the vagina and aid in inducing perspiration. Veratum Viride seemed particularly indicated and was given for several hours without any effect on pulse or temperature; then aconite, belladonna, gelsemium and bryonia were tried, each in turn; frequent doses for several hours without lessening the severity or tension of the fever. Later on pyrogenium, ferrum phos., echafolta, quinine and calomel all proved equally ineffective, the temperature remaining about 104°, pulse, 120 to 140; respiration, 40 to 50. All these remedies were not piled in together promiscuously, but were carefully administered as the symptoms seemed to warrant and watched closely until proven of no avail. Inasmuch as the patient was becoming nervous, with tendency to delirium and convulsions seemed imminent it was thought advis-

able to empty the uterus at once, even in the absence of any uterine action and in the face of the high temperature and existing symptoms. Accordingly she was fully anæsthetized (chloroform being used) and with the hand introduced into the vagina the os was steadily but carefully dilated. The placenta was found to be covering the os completely but implanted rather forward of the center so that it was feasible to work in behind it and by performing podalic version to bring down the fœtus and deliver with very little additional hæmorrhage. The placenta and secundines followed readily and a fair degree of contraction ensued so that that portion of the anatomy played little part in the subsequent proceedings.

The fœtus weighed about three and one-half pounds and though breathing freely and crying lustily at first with apparently good heart action, in spite of constant immersion in hot water, friction, brandy, amyl nitrite, etc., it died within an hour simply from lack of vitality sufficient to establish general circulation—the extremities remaining cyanotic from first to last.

The mother came out from the anæsthesia readily and seemed easier in every way, the temperature falling to 102° within an hour after the delivery and it seemed for a time as though the worst was over. But within a few hours the temperature had again climbed to 104° and it remained at or near that point until she died, which sad event took place within twenty-four hours after the delivery of the child and within forty-eight hours of the time of her admission to the hospital. In the meantime hot packs were carefully persisted in; high-up, hot saline enemata given (only to be rejected at once); saline infusion made under the left breast and intravenous saline infusion—up to three (3) pints in all administered, but not once did the skin relax, the pulse soften or the temperature waver. There were occasional flashes of delirium and loquacity and slight convulsive seizures, controlled by a few whifs of chloroform, but passiflora, stramonium and hyoscine hydrobromate had no apparent effect. Later on she sank into a low stupor, the respiration becoming more labored, not relieved by inhalations of oxygen, and as the heart action weakened hypodermic injections of camphorated oil, brandy and strychnia were of no more influence than so much water. So long as the stomach would retain anything (and there had been much vomiting from the first) she had been fed with dilute Valentine's meat juices, panopepton, milk and malted milk and an endeavor made to supplement this by nutrient enemata of the same, but the latter were persistently rejected, though the lower bowel had been previously cleansed by plain or saline injections.

On the whole it seemed as though—if our pathology be at all correct—with the onset of the acute attack of influenza ("grippe") there had taken place such a degree of bacteriological invasion of the system that the poor organism, weakened by the profuse hæmorrhages due to the placenta prævia and hampered by the existing pregnancy and all the impeded powers of elimination—due to the nephritis with its consequent accumulation of toxic products, was



utterly unable to stem the tide and carry on the battle and consequently succumbed to the overpowering force of unlimited numbers.

Though this case may not, perhaps, furnish much of practical suggestion as to what might prove of avail in another similar case—should such an unfortunate combination again occur—it can, at least, be a comfort to some to know that there are others in whose work the most carefully selected measures and the most assiduous care seem at times absolutely puerile in the face of the grim foe with whom we are battling from day to day.

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## PEMPHIGUS COMPLICATING PREGNANCY.

W. S. GARNSEY, M. D.,
GLOVERSVILLE.

The following remarks were made by Dr. Garnsey before reading his paper:

CHAIRMAN GARNSEY: The only excuse I offer for presenting this paper is that it seems to be a case of marked rarity, and also the fact that I was fortunate enough to obtain a photograph of the case, which is not always our privilege in a case of this kind; and it will please me if you will pass these photographs about the room so that you can see the illustration at the same time that you hear my description of it. There is a chance for a difference of opinion as to the diagnosis, and I hope some one will discuss it. I am sorry Dr. Dearborn is not here. He has had the paper and had consented to discuss it. In fact, at our Buffalo meeting I had a history of the case up to that point, and gave him a photograph of it, and also a copy of the history to that date.

My patient is Mrs. B. American; married; aged twenty-seven. Mother of two children. Nervous temperament, delicate appearance, very ambitious, doing dressmaking in addition to her household cares.

When a child, till the age of twelve, she was plump and rugged and in fine health. Then began a series of nervous troubles, and after a severe fright, she had chorea. From this time on she was thin, weak and nervous.

She married at twenty. During her two pregnancies her health was decidedly better than either before or after.

She had never been troubled with any form of skin disease or scrofula. Her father, however, and paternal grandfather had at times suffered with dry, scaly patches of skin resembling psoriasis, and her paternal grandmother had suffered, in her later years, so severely from a general pruritus, with no external manifestation, that she had to be kept quiet with morphine.

Both of her parents are now living and in good health. Her last menstruation was February 10-14th. She was quite overtired and debilitated and when she missed her period in March she did not improve in health as with the two previous pregnancies.

Toward the last of April, the end of her second month, one night after retiring she felt an irritation of the skin about the middle of the front of left leg. She rubbed it and thought no more of it until the next night when she discovered that a blister had formed and she had rubbed off its covering. Soon a similar bulla came on a corresponding part of the other leg. New blisters kept forming over the old ones, and also encroaching upon the apparently healthy adjacent skin, the patches thus growing larger and larger.

They then appeared over the adomen, and later on the thighs, and lastly on back and arms. The largest confluent patches were on the anterior and inner aspects of the middle third of both legs. The next largest were on the thighs. Some of the bullæ on the abdomen were quite large, but did not tend to run together. Those on the back were numerous but small and individual, and on the arms there were only a few and scattering.

The blebs were round or oval and varied in size from one-half of a pea to one-half of an egg. Large bullæ would raise in a few hours, sometimes even in two hours. There seemed to be a tendency to appear in crops every two or three days. The fluid in each was first clear, but would soon become purulent. The contents of the sacs would disappear by absorption, leaving a thin crust.

Most of the blebs on her legs were pricked early, as the nervous feeling caused by pressure of the fluid was more annoying than the smarting of the opened vesicle. After the bullæ were emptied, the rete mucosum, covered by the loosened epidermis, assumed all shades of red, according to the amount of congestion.

There was no inflammatory zone, the tissue immediately adjacent to a bleb, occurring on a new spot, appearing perfectly normal. But blebs would repeatedly raise on territory previously blistered and, of course, there appear surrounded by a dark patch, as seen in the large patches on front of both legs.

As previously stated, the first indication of the disease appeared the latter part of April, the second month of pregnancy. It increased very slowly and about July first she came to me to determine if she were really pregnant, as her symptoms had been so different from previous similar periods. She called my attention to the patches on her shins, which at that time were not very large. I admitted that I had not seen a like case, but thought it would not prove serious and gave a tonic, as she seemed weak and depressed. She had lost a child a few weeks before this. She seemed to improve in appetite and general condition but the disease progressed.

August first, I gave her a compound tablet containing iron, arsenic and ignatia. By August 15th the smarting and itching and nervous sensations had become so severe that neither she nor her attendants could rest at night. She was obliged to give up work entirely. I

PEMPHIGUS COMPLICATING PREGNANCY.
(DR. GARNSEY'S CASE.)

then put her on arsenicum, 3rd decimal trituration, a five-grain powder three times a day.

About a week later I gave these same powders six times a day, one after each meal of six meals.

About September first I changed from trituration to five drops of Fowler's solution of arsenic, after each of the three main meals. The photograph which you see was taken August 19th, a few days after beginning the arsenicum, and when the disease was at its height. From that time until her confinement improvement was marked.

When many sleepless nights had made her and her attendants almost desperate, I was compelled to give narcotics. A few nights, Park, Davis & Co.'s compound cerebral sedative was used, even three drams giving only partial relief. Then morphine and bromide potassium aided us for a few nights but by this time the external and internal treatment had so far improved her condition that valerianate of zinc, second decimal trituration, proved to be just what she needed and the last sedative required.

Among the external applications used, Mulford's compound salicylic acid ointment, benzoated oxide of zinc ointment and bichloride of mercury in solution gave little or no relief. A one per cent. solution of carbolic acid was a decided relief. Cloths wet in this were kept constantly on the parts, but owing to the large surface requiring it, too much acid was absorbed and we found the characteristic appearance of the urine and so stopped it.

Antiphlogistine applied to the large patches on her legs gave the most decided relief.

November 19th, after an easy and natural labor, she was delivered of a beautiful female child, whose skin was without a blemish. The child is now nearly three months' old, and as healthy and fair as one could desire.

At the time of my patient's confinement her skin disease was giving her but little trouble. The vesicles were not numerous and of small dimensions. She continued to improve for one week after delivery, and at that time her vial of arsenic being empty she neglected to obtain more. After being without her medicine three weeks there was a decided increase in the irruption and she came for more. Good results again followed the use of the arsenic, but at no time has the disease all disappeared.

February first, one large bleb appeared at the side of her ankle, one inch by half an inch in dimensions, and when last seen, February sixth, there were a few scattering vesicles on her legs, some of them as large as a cent.

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## DISCUSSION.

DR. ZWETSCH: *Mr. Chairman*, about six weeks ago I had a case of a young lady, 18 years old. I gave her morphine, and I gave her five drops of Fowler's solution of arsenic. She improved a little but

not very rapidly. They discharged me and called in an old-school physician, who gave her ten drops of Fowler's solution at a dose, three times a day, and in two weeks the girl was entirely well. I saw him and talked with him about the case about a week ago, and he said he doubled my dose and cured the case.

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# REPORT

OF THE

BUREAU OF PÆDIATRICS.

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"The Effect of Regents' Examinations Upon Nervous Children," by - - - - - DEWITT G. WILCOX

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## THE EFFECT OF REGENTS' EXAMINATIONS UPON NERVOUS CHILDREN.

DEWITT G. WILCOX, M. D.,
BUFFALO.

My paper is nothing more than a suggestion and if, as such, it should prove of sufficient importance to warrant an investigation, I trust this Society will appoint a committee of observing general practitioners, who shall collect data and facts relative to this matter and present the same at the next meeting for action. As physicians we are guardians of the public health and as such it becomes our duty to employ our experience and knowledge in the prevention of disease, physical disability and premature decay, quite as much as to restore those who have fallen victims to such conditions.

Nowhere can our efforts be better employed than in safeguarding the child, to the end that he may develop into a perfect being, capable of the greatest physical and mental strain which the becoming of a citizen of the present age must impose upon him. There is required no argument of mine to show that physical disability is but a poor legacy for citizenship, even though it be accompanied with the greatest intellectual acumen. The greatest benefactors of this world, whether found in the field of statesmanship, soldiery, letters or



philanthropy, have, as a rule, been men and women of marked physical endurance. Great and glorious as are our public schools and proud as are we Americans that we were the instigators of that system, we have not even yet grasped the full truth that the physical must be developed side by side with the mental and when there seems to be an issue between the two, the physical should in every instance triumph. I maintain that any system now in vogue in the public schools, whether it be the hours of confinement, posture at desk, method of discipline or gauge of the child's mental grasp, which in any proportion of the pupils subject to that system, tends to lower their physical endurance or threaten their future health even by one jot or tittle, such system should be abolished. The question I wish to ask and which I trust every physician present will so thoroughly investigate that he will at the next meeting be able to reply thereto with intelligence is: Do the New York State Regents' Examinations, as now held in our public schools, tend in the main to result injuriously to the physical welfare of the school children of this State? The other question: Is there any better method of gauging the child's mental grasp of a subject or of establishing a universal standard, by which all pupils must be judged, than such examination, is one with which the physician has nothing to do. It becomes his business to settle the first on its physical merits and leave the second for the educator to grapple. But we must see to it that however it may be settled, the child's future health shall not, in the slightest degree, be jeopardized.

While I do not believe that the Regents' Examinations, or, in fact, any term examinations as now held in the public schools are a true test of a pupil's grasp of a subject, yet were I convinced that such were the case and was equally convinced that such methods were harmful physically, even to a goodly minority of school children, I should emphatically condemn it. Now, as to the evidence of physical harm. I believe there are but few observing parents in the State of New York, who have children in the public schools who would not be able (had they no other evidence) to know with a certainty the time of an approaching Regents' Examination simply by the nervous apprehensive, excitement, irritability, loss of appetite or sleeplessness manifested by the children who were preparing for such examinations.

Again, there are but few observing parents in the State of New York, who have children in the public schools and who would not be able to know that such examination had just taken place by the evidence of physical exhaustion, nervous exhilaration, hysterical emotions or absolute collapse. I am further of the opinion that if every doctor engaged in active practice would take the pains to observe, he would discover that he is called to attend more school children immediately after Regents' Examinations than any other time of the year, seasons of epidemics alone excepted. Furthermore, if his investigations were thorough, he would observe that there was present in nearly every case, a high state of nervous and mental

excitement, which had so exhausted the slender reserve force that resistance to disease, which we call immunity, was so much lessened as to leave the little patient a subject to almost any malady that happened to present itself, whether catarrhal, cold, brain fever, typhoid or even scarlet fever.

A condition which I should like to see investigated, and which I present as a question for research is this: Do not our epidemics amongst school children, as a rule, occur about the time of Regents' Examinations, and if so, can it not be attributed to the fact of the lowered state of vitality and the consequent lessened degree of immunity from which the child at that time suffers?

As a rule, the robust, healthy child has less anxiety and shows less nervous irritability over examination than does the sensitive, delicate and precocious child, hence, the latter, who really has less reserve power and less energy, is the one who should not be subject to an ordeal twice a year, which he is in no wise fitted to meet.

I am of the opinion that these semi or thrice yearly examinations, occurring in the younger school life of sensitive children are the main cause of the nervous breakdown and collapse exhibited in later life amongst college women and are traceable, not to hard study in college, but to the worry, anxiety, indigestion and sleeplessness consequent upon the Regents' Examinations which occurred in young school life.

I have in mind three little patients of mine, young girls in the primary grades, and consequently not subject to Regents' Examination, who have no difficulty in keeping up with their classes and who are in reasonable good health and able to attend school daily until the time of the term examinations. Then they begin to complain; one has indigestion until she suffers severely; another has headache and difficulty with her eyes, of which she never complains at other times; and a third invariably has sore throat. After the examinations are over they are little wrecks and must remain out of school for a number of days to recuperate; then they will again take up the work and remain well until the next period of examination. I am convinced that such cases are only examples of many which every physician can produce and if such is the case, certainly the physician should make the truth so manifest that it shall receive the attention of our educators.

There is no system—I care not how necessary or beneficial to the advancement of the child's education—which in its operation causes a lowering, of the physical stamina of the developing child, which should, for a moment, be tolerated.

We made a great step forward when athletics became a part of college education, but we have much to do yet amongst the small school children, who are in the most plastic state of physical and mental development, and who, if injured, while at that tender age, rarely recover the lost stamina or physical vigor. There is much that requires correction in the physical school life of the young in order that the children may attain to perfect physical man and



womanhood, but the one particular error, which I am convinced this State is making towards its younger pupils and I should specifically speak of children between the ages of eleven and fifteen years, that very impressible and critical age of puberty, is the subjection of such children to a twice yearly ordeal, which is of questionable benefit mentally and to my mind is one of the greatest factors in the production of nervous irritation and physical ailments to which the school child is subject. (Applause.)

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## DISCUSSION.

DR. LESEUR: *Mr. Chairman and Members of the Society*, I am of opinion that Dr. Wilcox has touched upon a subject which lies very close to the heart of every active practitioner, even though he may not be a parent. I believe that every person who is at all conversant with the every-day life of school children is convinced without the necessity of any particular argument, simply from his own observation, that the method in vogue which has been inaugurated by the State Board of Regents, and which has approximated what they now call an "ideal method," a "perfect method," as some one has said, is a method which is unwise in its active use, unsafe in its operation and injudicious in its continuance under present rules of the State Board of Regents. I say this after having looked over the matter with some careful thought, and after having tried, as some of you know, in our National Society, to gather statistics bearing upon this point, and after having endeavored to secure such facts bearing upon the physical development of the child in relation to his mental development as would enable me to judge righteously; for, I believe, no single case can be a criterion; I believe no statistics are valuable except they be gathered with such care as to give us an opportunity to generalize. No individual case gives us the right to an opinion, but a series of cases carefully collected and compared does give us a right to an opinion from which there is little opportunity to appeal. I believe that among the unwise things in connection with the present system of examinations by the State Board of Regents, is the almost universal custom of allowing the standing of the child to be governed by the examination taken under the supervision of the Board of Regents. I think that is radically wrong. I think there should be in every school a system of daily marking, and that the standing of the child at the end of the school year should be made up eight-tenths from the daily marking and perhaps two-tenths from the examination conducted under the supervision of the Board of Regents. I say this because I have had some little experience as a teacher, and some little experience in this particular work, before I began the practice of medicine; and I know that what Dr. Wilcox has stated to us is absolutely true. And, a final word: I believe it is our duty as physicians to do something about it. (Applause.)

DR. NICKELSON: *Mr. Chairman,* I am greatly pleased with this paper of Dr. Wilcox's because it comes to the point, as do all of his papers. In our small town I probably know nearly every child of school age, and especially the young girls. It is not the dullest scholars but our brightest ones who dread our Regents' Examinations. In a set of girls of about twenty, of which my daughter is one, I have the means of knowing. It is the children in the class that carry the purple seals, some of them two and three, that dread these examinations. Those who are dull do not care whether they pass or whether they do not. I have seen girls that never have failed to pass any examination, who carry two and three purple seals, which means that they have passed all of their examinations with a marking of ninety or more, to be sick the day after they passed their Regents' Examinations. I know two or three that are going to graduate at the age of 16 or 17. They wish to go to Wellesley College. Massachusetts schools will not take our Regents' graduates or pass cards, and these students have come to me and said: "Doctor, I can't go through all those examinations again. I have to pass the four years' classical course which I have taken in our high school, beside all of my preliminaries. I hold the purple seal for the State of New York for my primary, and my first and second year's academic, and never have failed in an examination—what shall I do?" Those girls are simply wild, and they have been wild three times a year, every time that our Regents' Examination comes out, and I tell you, ladies and gentlemen, as members of the State Society of New York, we ought to draw the dividing line. If the young must pass these examinations we should have some arrangement whereby they can go into another state and be allowed to enter college upon their Regents' pass cards and not be compelled to again go through an examination on these same subjects.

DR. WILCOX: *Mr. President,* just a word in closing. I have talked with a number of teachers and principals in regard to this matter, and almost universally they condemn the Regents' Examinations, and for the matter of that, the term examinations as well; first, because they are not true tests of the child's scholarship, and, second, because of the ill effects physically. Most all of these teachers would be glad to do away with these examinations if it could be done. I talked just the other day with a very able teacher, who said she had taught for four years in New York State and four years in another State where they did not have the Regents' system, and she felt she was able to judge to some extent between the two. I asked her if she would tell me just what she had observed on those two points. She said, "I have no doubt regarding it. In the Regents' Examinations in New York State, after the examinations were over with, my school came almost to a standstill for a matter of three or four days or a week, simply paralyzed. The chilren had not got over the effects of the examination, and they did nothing for three or four days, sickness and ill health and complaining was so general and universal. In the other place where I taught for four years and there were no



examinations whatsoever, not even term examinations, there was a higher and more healthful state of scholarship. The standard was that of the daily marking, according as the pupil was able to recite each day. There were no term examinations whatsoever." There was not that general absence, nor the sickness and ill effects that she had observed where the Regents' Examination was held. I am convinced we can do away with the term examinations, with the Regents' Examinations, especially in the lower grades, and that a great deal more healthful state of scholarship would result, as well as a truer test of what the child is doing, than where the examinations are held; and I believe it is for the physician to determine this matter. (Applause.)

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# REPORT

OF THE

## BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

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## THE EYE LESIONS CONSEQUENT UPON MEASLES.

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Measles has such a strong affinity for the structures of the eye, and is so frequently attended by ocular lesions, that a consideration of the latter may be of mutual interest to the general practitioner and the specialist. Measles may affect all the structures of the eye, from the skin covering the lids to the deeper structures, like the optic nerve. Some of them are familiar to the general practitioner, in fact, more familiar to him than to the specialist; but others, especially those most grave in their bearing, are known more commonly to the specialist.

Commencing in anatomical order with the lids, we find the

epidermis covered with the rash like other parts of the face, presenting, however, no special features in this situation.

Marginal blepharitis is a common complication. It may occur during the progress of the general trouble, but it is most common later. It is characterized by redness and swelling of the margin of the lids, and the formation of little scales or crusts which are very adherent to the cilia, so that efforts to remove them are frequently followed by loss of some of the lashes. While it may occur alone, it is often accompanied by conjunctivitis eczematosa which will be spoken of later.

There has been observed during convalescence in some cases of measles, that the meibomian glands, both on the upper and lower lids, become inflamed and suppurating; the pus finding an outlet upon the inner surface of the lid by breaking through the tarsus and conjunctiva. Several such cases have come under my notice.

Every one is familiar with the fact that the mucous membranes of the eyes and nose and the tear passages connecting them are inflamed. It is then easy to appreciate how obstruction of the tear duct and inflammations of the lachrymal sac are sometimes sequels of measles.

Characteristics of measles, and coming on before the appearance of the rash and even before the pyrexia, is acute conjunctivitis which manifests itself in the usual way by redness, swelling, lachrymation, and photophobia, the latter often intense. The secretion is acrid, causing irritation and swelling of the skin over which it flows and often producing cracks at the canthi. Conjunctivitis usually increases in severity, attaining its height during the height of the pyrexia, after which it declines and subsides with the general disease. Often, however, it persists for some time subsequent. Unhappily, conjunctivitis does not always follow the benign course just described. Upon rare occasions it assumes the diphtheritic or blennorrhœic type without ever becoming, however, true diphtheria or blennorrhœa. Naturally in such cases the integrity of the cornea is threatened. In my experience the most common eye sequela of measles is conjunctivitis eczematosa or phlyctenularis, as it is more commonly known. It is due to the dyscrasia produced by the general disease. In its most simple form one or more small, grayish elevations appear at or near the corneal border accompanied by a characteristic injection triangular in shape, the apex corresponding in each case to the phlyctenule. There is considerable photophobia and lachrymation. The phlyctenule gradually breaks down with a slight loss of substance, affecting merely the epithelium and then heals. Relapses are quite common. The disease is not always so simple, especially in strumous subjects. The acrid lachrymation excoriates the skin of the lids and face, producing scabs, blepharitis and swelling of the lids. At the same time the photophobia becomes so intense that spasm of the lids occurs, and the child shrinks to a darkened corner of the room and buries his face in his hands. It now requires dexterity to separate the lids and inspect the cornea, which must be done daily notwithstanding, and the efforts to do so frequently cause bleeding of the lids especially



at the canthi where the skin is cracked. Frequently a muco-purulent conjunctivitis is present in addition. The importance of inspecting the cornea daily cannot be too firmly impressed upon the mind as ulcers of the cornea often occur. Not only do ulcers of the cornea occur in conjunction with conjunctivitis eczematosa but they are often found alone. This is especially true of the ulcus serpens or abscess which appears under the form of a grayish or yellowish disc-shaped opacity at the center of the cornea, the opacity being greater at the circumference of the disc than at its center. Surrounding this disc is a delicate gray area and radiating from it are fine gray striæ which extend into the transparent cornea. The corneal surface corresponding to the disc is dotted and at first may be raised above the level of the surrounding surface, but soon it shows as a shallow depression. Associated with it is a violent iritis and pus in the anterior chamber. The ulcer extends in a crescentric shape and becomes deeper and deeper until finally perforation may take place with escape of the aqueous humor and entanglement of the iris in the opening. The disease may stop at this point or go on to the total destruction of the eye by panophthalmitis.

Even more destructive a sequela is keratomalacia, or softening of the cornea, a disease confined to childhood, fortunately not very common but sometimes following measles. It first appears as a dryness of the conjunctiva, especially of the part corresponding to the palpebral fissure. Here triangular dry patches are found which are glistening and have an appearance as if they were smeared with grease. The lachrymal gland secretes tears but they run over these spots without moistening them. Subsequently the dryness extends over the entire conjunctiva and over the cornea. The latter becomes cloudy, then disintegrates and finally breaks down into pus. The prognosis is bad as in most cases they not only lose their eyes but their lives.

Like diphtheria, measles sometimes causes paresis of the muscle of accommodation. It is easily recognized by inability to read fine print at the ordinary distance, fourteen inches (unless the case is extremely near sighted), while distant vision is not affected (except in cases of well marked farsightedness).

Before proceeding to the most interesting of the intraocular disturbances, I would mention in passing that purulent choroiditis sometimes, though rarely, follows measles, and that it is generally destructive to the sight as well as to the eyeball itself.

A number of cases of blindness due to neuritis have been reported. They may occur during the attack of measles or following it. A study of them permits of a clinical division in two classes. First, retro-bulbar neuritis, where the ophthalmoscope shows either no eye lesion at all or only late in the history of the case; and second, optic neuritis, where the ophthalmoscope reveals the usual changes in the papilla from the start.

The histories of the cases in the first class seem to indicate that they are due to a lesion of the visual center in the occipital lobe;

because, despite the blindness, the pupillary reflex persists. In one case where a post-mortem was made, though some years after the attack, a lesion was actually found in this situation. If the primary lesion is restricted to the visual center, however, it will not account for the haziness of the papilla and retina, which often appears later. This can only be accounted for by consecutive retro-bulbar neuritis. In the majority of the cases the onset was sudden; it was ushered in with head symptoms and the blindness was pronounced when first recognized. Their subsequent course was followed by recovery in some instances and permanent blindness in the rest.

With reference to the second class, where optic neuritis manifests itself from the start, the opinion is held that they are due to meningitis. Not necessarily meningitis with delirium, fever, opisthotonos, etc., as is ordinarily implied by the term, but a more localized inflammation of the membranes in the vicinity of the chiasm. Cerebral meningitis is so rare a complication of measles that some of the text-books on diseases of children do not mention it. Some of the reported cases of optic neuritis following measles, however, were preceded by a well worked meningitis while others apparently had none. The latter cases, however, it is supposed, had a localized inflammation of the membranes near the chiasm. The cases of optic neuritis seem relatively more frequent than those of retro-bulbar neuritis and their histories would seem to indicate that the prognosis is worse.

Optic neuritis can also appear in a more roundabout way. The middle ear suppuration so frequent after measles may by extension of the inflammation to the brain or its membranes cause optic neuritis.

After saying so many hard things about measles it is a relief to be able to record that it may rarely have a beneficial effect upon the eye as it has greatly benefited a case of trachoma with pannus.

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## DISCUSSION.

GEORGE W. MCDOWELL: The diagnosis, prognosis and treatment of eye diseases due to measles is of prime importance to every general practitioner; for disease of the eye like that of every other organ is most responsive to treatment when in its incipiency. The possibility of loss of vision is always present in eye diseases, but by an early recognition of the trouble and its appropriate treatment, this may generally be prevented.

We often see children greatly disfigured by eyes framed in red eye-lids on which are seen crusts and scales of dried mucus—a condition at once disgusting to the observer and a source of mortification to its victim. Such a state of things often results from an attack of measles in which the eye symptoms have been considered of slight moment and have received but scant attention. Cases of this kind often become chronic because of an underlying refractive error which of itself was not sufficient to cause a marginal blepharitis, but which becomes an important factor in the continuance of the trouble when once the conjunctiva has become inflamed as a result of one of the eruptive diseases of childhood. Here, in addition to the local and internal treatment it will be often necessary, before a cure can be effected, to examine the refraction and prescribe glasses for the correction of any existing error. One of the best local applications is the yellow oxide ointment in the strength of four grains to the ounce, being sometimes sufficient to effect a cure without other treatment. In strumous children, however, both internal medication and dietetic management will be needed to reinforce other methods.

The little abscesses which form around and in the meibomian glands may be opened and their contents discharged, thus cutting short the suppurative process by several days.

For the conjunctivitis of measles, which may assume a mucopurulent character with a tendency to ulceration of the cornea, frequent cleansing of the conjunctival sac by flushing it with a weak bichloride or boracic acid solution is of the greatest importance. A drop of a three per cent. or five per cent. solution of protargol will hasten resolution. Internally aconite, euphrasia, argentum nitricum, pulsatilla and rhus tox are of positive value, but should not be relied on to the exclusion of local cleanliness and antisepsis.

Phlyctenules of the cornea are apt to break down, forming ulcers. If these are located over the central part of the cornea the pupil should be dilated by instillation of a one per cent. solution of atropine; or when located near the corneal margin a one-half per cent. solution of eserine should be used to contract the pupil. The object in either case is to withdraw the margin of the pupil from the site of ulceration, so that if perforation of the cornea should unhappily ensue as a result of ulceration, prolapse of the iris through the opening thus formed may be averted. If iritis coexists with corneal ulcer eserine must never be used as the contracted pupil which it causes is very likely to become adherent to the anterior surface of the lens

and the pupillary area become blocked by plastic exudate of the iris.

In ulcer of the cornea, as in muco-purulent conjunctivitis, healing is promoted and the extension of the disease retarded by flushing the eye freely with a 1-5000 bichloride solution. Internally the calcareas and hepar sulph. are the remedies most commonly used in this condition.

The paresis of the ciliary muscle, which, as Dr. Helfrich has mentioned is sometimes found as a sequel of measles, may be the occasion of great alarm on the part of the parents as well as the patient, to whom the inability to see at the near point may appear as a certain sign of impending blindness. A simple statement of the true condition will quickly remove the burden of anxiety. While usually of comparatively short duration, the paresis may last for weeks after general convalescence and seriously interfere with the child's school work. The remedies which, in my experience, have proven most satisfactory have been gelsemium and zinc phosphide.

I can add nothing to the very complete paper which Dr. Helfrich has presented to the Society and have confined myself to a brief reference to the usual methods of treating the common external diseases affecting the eye as a result of measles.

DR. MOFFAT: I think it would be wise to emphasize one or two things to the Society: During measles not to keep the patient in too dark a room; avoid a glare or an uncomfortable amount of light; and not to neglect a red eye, a little cold in the eye at that or any other time. I am treating now a patient with virulent iritis, in whom my best efforts, everything that I can think of except operation, have failed to break up the adhesions, because the family doctor who was attending him for rheumatism ( a so-called "regular"), said it was "a little cold and didn't amount to anything."

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## THE EAR COMPLICATIONS OF LA GRIPPE.

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Since the epidemic of grippe in 1889-1890 the profession has become very familiar with the various phases of this infectious disease. The complications have been described and discussed extensively, but those of the ear seem to have occupied a less prominent position in the general discussion, although aurists frequently see patients who trace their first ear trouble to an attack of grippe.

For practical purposes the ear may be considered as an off-shoot of the naso-pharynx, and bearing this in mind it is easy to conceive the likelihood of the involvement of this accessory cavity whenever



the naso-pharynx becomes affected with an inflammatory condition, and more especially when the effection is due to a virulent bacillus, such as that isolated by Pfeiffer and others.

The naso-pharyngeal symptoms are often severe and simulate those of a rhinitis, with the engorged turbinated bodies, profuse secretion, stuffy ears and naso-pharyngeal discharge.

According to Osler, "The bacilli are present in enormous numbers in the nasal and bronchial secretions of patients, in the latter almost in pure cultures. They persist often after the severe symptoms have subsided."

Given approximately normal nares and previous freedom from naso-pharyngeal catarrh, the likelihood is that an acquired influenza will not be complicated by severe aural symptoms.

In health, the ciliated epithelium of the eustachian tubes has a motion from the tympanum toward the pharynx. It is in cases, in which the normal function of the eustachian tube is destroyed, that the most severe ear complications are observed. These factors are important elements in considering the final outcome of grippe, and a prognosis in the early stages of the disease should take into consideration the possible involvement of the auditory apparatus.

From careful observations of the past two years, it is the writer's opinion that the effects of grippe upon the auditory apparatus may be designated as immediate and remote.

The immediate complications may vary from a simple hyperæmia of the tympanum and neighboring tissues, to a severe purulent otitis media and mastoiditis.

The remote effects follow within a few months, or a year or two, and are due to the chronic hyperplastic inflammation set up within the eustachian tubes, and as a result of the stenosed condition of the canal labyrinthine symptoms develop, as evidenced in vertigo, and tinnitus, and objectively sunken and thickened membrana tympani and rotated malleus.

Bearing in mind these possibilities, the utmost care should be assumed to prevent otological involvement. If the patient has been suffering from a chronic naso-pharyngeal condition requiring treatment, it naturally follows that the acute naso-pharyngeal symptoms of influenza require still greater care, and for this purpose the nares and pharynx should be carefully cleansed of discharges, and the stuffy sensation within the nose combated by some drug capable of relieving the engorged turbinateds, and permitting easier nasal respiration. This treatment indirectly affects the ear by cleansing the region of the eustachian orifices, of infected discharges, and renders less likely any severe extension to the tympana.

If despite treatment, the ears do become involved, the first evidence complained of by the patient is earache, and this symptom should call for the immediate inspection of the membrana tympani, and before serious involvement of the tympanum, paracentesis should be performed. If expectant treatment is necessary, then dry heat is more soothing than other measures, combined with the proper remedies.

However, in this instance, we are dealing with a virulent bacillus infection, and radical measures are safest, for with a properly performed paracentesis, tension is done away with and we are able to treat the tympanum antiseptically, with the proper germicidal solutions. Delay means possible mastoid involvement, with the necessity of an operation required to relieve that most serious condition.

An important consideration is the retaining as near a normal patency of the eustachian tubes as is possible and this may be done, when feasible to pass the instrument, by inflation, through the eustachian catheter, or if, because of intra-nasal deformity its use is impossible, then inflation by means of Politzer's method is indicated, but a necessary preliminary in the use of either of these methods is the previous careful cleansing of the naso-pharynx.

Convalescence from the systemic disease ensuing, and the aural complications subsiding with final recovery, it is then due the patient that an examination of the auditory apparatus be made to determine possible permanent injury, or effects that may be overcome through treatment, and this examination is not complete unless the naso-pharynx is inspected, and the degree of patency of the eustachian tubes determined.

The influence of diseased conditions of the naso-pharynx over pathological conditions of the ear, is no longer a matter of discussion; therefore, treatment directed to the cure of aural conditions subsequent to grippe requires operative measures for the removal of septal spurs, deflected septa, synechiæ or any other pathological conditions, within the nares. The eustachian tubes should be rendered thoroughly patulous by the use of bougies. These measures are particularly indicated in young people giving a history of deafness in the family.

The consideration of cases from active practice are not alone interesting but instructive; therefore, the following are submitted:

Case 1. Mr. R., æt. 69. This represents the immediate complications of the ear, attendant upon an attack of grippe.

The patient had been ill for about one week, confined to his room, but not to his bed. Having experienced some stuffy sensations in the ear, like those noticed in previous colds in the head, he had thought little of them until severe pain in the right ear led him to mention the earache to his attending physician.

The pain being unrelieved by remedies, I was asked to see him. Examination revealed a much reddened and swollen membrana tympani, the nares were occluded, and it was found that the aural complications had selected the side in which there was a nasal obstruction, due to a septal spur.

Without delay a free incision was made in the posterior inferior segment of the membrana tympani allowing a free gush of mucosanguineous matter followed by relief of pain, and later copious discharge of pus. The nares were cleansed and an attempt made to pass the eustachian catheter, but on account of the septal spur, this was impossible, so inflation was performed by means of Politzer's method.



This first paracentesis was performed March 6th, and the ear continued to discharge more or less freely until April 23rd, when the ear was apparently well, hearing contact, but on May 6th he complained of pain again, which was only somewhat relieved by remedies and dry heat. Four days later it was again necessary to open the membrana tympani. The recovery from the relapse was rapid and by the middle of June he suffered no inconvenience except that sounds were somewhat muffled, and there was more or less tinnitus. This passed away while taking chen.$^{3x}$ Tests of the hearing taken one year after cure showed the following:

Watch $\frac{50}{90}$

Fork B. C. $18^{sec.}$ A. C. $50^{sec.}$

Case 2. Miss C., æt. 40. This patient presented much the same course as the former patient, with early involvement of the middle ear.

She was seen April 2nd, 1901, and failed to respond to treatment, except that the earache was relieved.

Repeated paracentesis of the membrana tympani and cauterization of the resulting opening proved unavailing in establishing a free exit for the pus. The discharge was free one day, and moderate the next, then again profuse. Finally the advisability of a mastoid operation was suggested but refused, so local and general treatment was continued, however, without avail, for on June 16th pronounced mastoid symptoms appeared, the discharge ceasing suddenly and marked mastoid tenderness ensuing. The application of cold and remedies was followed with a subsidence of severe symptoms.

Discharge was re-established through the external auditory canal, but mastoid tenderness continued. The time for further delay had passed, and operation was insisted upon.

A radical mastoid operation was performed on June 30th, and the entire mastoid process found filled with decayed bone, decomposed blood and pus. The ossicles were in good condition, so they were left *in situ*.

Recovery was as rapid, as the previous ear disease had been prolonged, and normal function of the ear was finally established, and the patient has since gone to a Western State to live.

Case 3. Mr. H., æt. 48. Represents the immediate and remote effects of grippe. Purulent otitis media followed within a week, both ears being involved, at which time I saw him in consultation, this being April 14th, 1900.

Perforations having been established, it was not deemed necessary to enlarge them. Four days' treatment caused a cessation of discharge from both ears, and a week longer was necessary to establish sound membrana tympani. At this time the eustachian tubes were found clear, but some injection along the handle of the mallei remained. Patient was given kali mur. and advised to return in a short time. However, he failed to do so, as no trouble seemed imminent, but early in January of this year, he came for examination, stating that he was troubled with noise in the head, localized to the

left side, and having lasted for six weeks. Examination of the ears revealed almost complete stenosis of the left eustachian tube, with hearing considerably impaired.

Treatment consisted in passing bougies through the eustachian tube which revealed four distinct strictures; these yielded to firm pressure and later the bougie was passed completely into the tympanum, the head being recognized through the translucent membrana tympani.

At the present time the noises have greatly ameliorated, and the patient enjoys excellent hearing and general health. The ear that was affected by the remote effects of the grippe, is on the same side as an existing septal spur which presses upon the inferior turbinated during any acute affection of the nares, but which does not prohibit the passage of a catheter.

All of these patients were affected with chronic naso-pharyngeal catarrh, and in two septal spurs were present on the side of the ears affected.

In one the patient is too far advanced in years to make operation feasible. In the other operative measures are under advisement. The third patient had no condition of the naso-pharynx that would be amenable to operative procedures but requires treatment for her catarrhal condition.

Briefly, prevention is better than cure. The doctor who forestalls aural complications deserves greater credit than he who cures through treatment or operative procedures.

The use of a properly applied nasal douche and pharyngeal spray or gargle, of normal saline solution, Seiler's solution or any other similar preparation, will many times save the patient much suffering and possible loss of hearing.

Later treatment necessitates the accurate knowledge as to the conditions of the tympana, eustachian tubes and the naso-pharynx and any abnormalities of the naso-pharynx that might interfere with the cure of the aural disease should be corrected by operation.

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## DISCUSSION.

H. D. SCHENCK: I regret to say that I received the copy of Dr. Dowling's paper so late that I have not had time to prepare as carefully as I would like to have done for a discussion of the many excellent points in the paper, but wish to emphasize a few of the more prominent ones and bring out possibly some of the treatment that may be useful to general practitioners in coping with cases of this kind and in preventing the aural complications. In the first place, I think the doctor has included in the term "grippe" too large a title. Many of its forms affect the nervous system and the abdominal organs where, of course, it has no relation to the ear. It is only in the older and more typical form of influenza that we



get the effect upon the nose and ears, and it is in those cases that we need to be very careful about the aural complications. In those who have, as the paper states, any catarrhal condition of the nose or any predisposition to ear trouble, the conditions should be very carefully watched with "grippe," and at the very first sign of earache the utmost care should be taken to prevent extension of the trouble beyond the stage of hyperæmia. Of course in the aural complications of "grippe" the intensity of the symptoms is much more marked than in a simple catarrhal inflammation due to the poison of "grippe," whether it be bacillus or something else, and the hyperæmia in the middle ear by the extension of the inflammation through the eustachian tube. In the middle ear there is often a very rapid destruction of the tissues and an extension to the mastoid, which should always be very carefully watched. If you have earache, and even sometimes without it, deep palpation over the antrum and apex of the mastoid region should be carefully and frequently done in order that the first sign of mastoid involvement may be avoided. I recently saw a child, a case which was not a complication of "grippe," where both mastoids were involved and where the early treatment of the boy by the continual use of ice-water irrigation through a rubber bag applied on the mastoid, with the internal remedy, prevented trouble where it looked as if it would be necessary to have an operation at one period. Of course, as the paper states, you must very carefully inspect the membrane and be prepared to perform paracentesis if there is bulging, in order to let the middle ear have free drainage outward and prevent extension of the pus into the mastoid. I believe if you make a free incision into the membrane and find pus there, that you can do no better than cleanse it by using peroxide of hydrogen diluted somewhat as an injection. I think this will clear out every bit of pus; and that it should be followed by irrigation with some antiseptic solution. The eustachian tube is often opened by this method of treatment and furnishes an additional means of drainage. If the eustachian tube is not opened in this way it is best to gently open it by using the Politzer bag or the catheter and gently inflating the middle ear. It is well to cleanse the nose, as the paper states, and to use either Siler's solution or some other good alkaline preparation. One of the best methods of using these and one which you can trust to your patients, I think, with perfect safety to the ears, is the use of the Birmingham douche. It is a valuable method of cleansing the nose, and can be used frequently, so that the nasal cavities and pharynx will be kept perfectly clean. If this or a post-nasal syringe is used before any attempt to inflate the ear by the Politzer bag or any other method is used, it can be done with perfect safety and with the assurance that you will not, probably, infect the middle ear with any of the germs of the poison of the "grippe" that may be present in the nose or pharynx. I believe there is another very important point to avoid. Doctors do not advise it so much now, but the laity have a great disposition to snuff salt and water up the nose from the hand. That is a very reprehensible method, and one of the valuable members of this

Society, I think, would be living to-day if he had not, against the advice of all his friends, persisted in the use of this method. He had the "grippe," and insisted on snuffing water up his nose to cleanse the parts. He was conscious the moment the water went into his ears which set up a violent inflammation of the middle ear, and through the pain and suffering from it he committed suicide. I think it is a practice that must be avoided, and that we ought all to speak to our patients about avoiding it. Sometimes we do not know what they are doing. It is well to find out how they are cleansing the nose. I find they will often do this without saying anything about it, supposing they are doing the right thing. By all means prohibit it. (Applause.)

F. PARK LEWIS: May I add a word, Mr. Chairman, to emphasize the necessity, as I did this morning, in grippe, diphtheria, scarlet fever and measles, of being assured that the naso-pharynx is free from adventitious growths. Adenoids complicate the condition, and they should be removed if they exist. It is sometimes a question whether it is not necessary to remove adenoids during the progress of acute inflammatory processes. In a case of measles in my observation in which mastoid complications followed, that question arose, and it was one which I had great doubts in my mind in determining, whether during the illness of the child, with the acute fever process existing, operative interference ought not then to be made. I regard acute inflammatory processes, suppurative processes of the middle ears, closely analogous to the condition we find in ophthalmia neonatorum, and bearing that in mind, I combated a case of mastoid involvement in this child in a way that was so satisfactory to me that I think it is worth recording. The child was developing severer symptoms, the fever running to 103 in the afternoon and becoming sub-normal in the morning, a definite sepsis, deafness, and a profuse purulent discharge. In that case, after cleansing the ear with an antiseptic solution, I used a twenty per cent. solution of protargol, allowing the child to lie with the head down and then working it in in such a way that it went back in the mastoid. In twenty-four hours the temperature was down to 102. The next day it was 101, and the whole condition was absolutely aborted without the necessity of operative interference. I think this is a very important matter. It is not always easy to obtain consent to operative interference in those cases, nor is it ever a simple matter to open the maistoid in a child; and if, under the care of a judicious surgeon, it is possible to abort a process of that kind, we gain much, and it seems worth making that note here.

FRED LEWIS: *Mr. Chairman*, I would like to find, if I can, where Dr. Schenck draws the line or the difference between snuffing salt and water as mentioned by him and the use of the Birmingham douche. I know the Birmingham douche is very generally used, and I have always gone against its use, for this reason—that in the arrangement of the epithelial lining of the nasal mucous membrane, nature never intended that fluid substances should be drawn from before backward. The arrangements all are to carry fluids from the



back forward; so that I think the only safe, thorough cleansing is by the use of a post-nasal syringe. And, again, in the use of fluids, the eustachian cushion is not prepared to prevent their entrance if the fluid is taken from before backward, but it is if they are thrown from behind forward; and I would like to know where Dr. Schenck makes the difference between the use of the Birmingham douche and the snuffing of water from the hand.

DR. SCHENCK: I think there is a vast difference, Mr. Chairman; because, in the first place, in snuffing water up the nose there is a muscular contraction which you do not get at all in the use of the Birmingham douche, and the fluid is thrown through the nares with very much greater force than with the Birmingham douche, where it runs through almost by the force of gravity. I have never seen any trouble arise from the use of the latter, especially when used as I am in the habit of using it, with fluids that are of somewhat greater specific gravity than water, and using it faithfully. I would like to say in passing that it is well to be on the lookout for mastoid disease in these catarrhal cases as well as all others, because mastoid trouble is very much more prevalent now than it was ten years ago. In the New York Eye and Ear Infirmary it was recently stated that they have more than ten times as many cases now as ten years ago, and it is much more common to see a bulging membrane and the mastoid process tender now than it was ten years ago. In the Infants' Hospital in Brooklyn, with which I have been connected for a long time, it was the rarest sort of thing ten years ago to have a child with mastoiditis. For the last three or four years we have had one to two a year requiring operation.

DR. MOFFAT: What remedy does Dr. Schenck use to abort the mastoiditis? What treatment did Dr. Dowling give where the case was discharged in a few days? I endorse very strongly what Dr. Dowling said about the necessity for the thorough cleansing aseptically of the upper vault before inflation by valsalva or eustachian catheter. Some patients fortunately can use the post-nasal syringe. The majority of them cannot be trusted or induced to do it; if I cannot get them to use that I use now the half-ounce glass syringe with a blunt point, in preference to the Birmingham douche.

DR. DOWLING: In reply to Dr. Moffat's suggestion, the only solution I used was bichloride of mercury, 1 to 5000, and the remedies at first were ferrum phos., and later hepar sulph., 3d x.

DR. SCHENCK: Hepar sulph., 3d x., was the remedy used in this case.

# REPORT

OF THE

BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.

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## A REMARKABLE CURE WITH A SINGLE REMEDY IN A SINGLE DOSE, GIVEN HIGH.

GEO. E. GORHAM, M. D.,
ALBANY.

*Mr. President and Members of the Society:* My apology, which I frankly offer for reporting a single case is that the case was well marked, the diagnosis unquestionable and the cure so prompt that it seemed to me a valuable lesson might be drawn from a short consideration of it. On November 27th, 1901, at 10 a. m., I visited B. H., a vigorous young man, aged sixteen years, who gave the following history: On the afternoon of the previous day he had a few slight chills, headache, backache and was very tired. He left his work at 4 p. m. and went to his home, where I found him in bed the morning of my visit. He was dull and stupid, inclined to sleep all the time. A heavy, throaty breathing, sub-maxillary and parotid glands swollen. Tonsils swollen and of a dark purple hue. A blackish gray coating covered about one-half the surface of each. A very offensive odor filled the room so that the mother's words as I entered were: "I never smelled anything so bad as Bartlett's breath."

The temperature was recorded at 102° and pulse at 84. The throat was sore and the patient complained that he could not swallow food and said he was so tired and ached all over.

I diagnosed diphtheria, gave a placebo and said I'll return at 4 p. m. This gave six hours in which to decide upon the indicated remedy. Lillienthall mentions twenty-three different ones beginning with ailanthus and ending with sulphuric acid. These were



given; our Copperthwait, Allen, Farrington, Raine and Goodno were all studied and at 4 o'clock I went to the house, confident that I had made the one selection for the case. I gave the one dose and called at 7 p. m., three hours later. Pulse, 80; temperature, 102. Same as when the remedy was given. I felt sure the throat was no worse and the coating not extended. Therefore, decided to wait further action of the dose before changing or repeating it. The next morning, November 28th, at 10 a. m. I received a report from the Bender Laboratory confirming my diagnosis of diphtheria. I went to my patient with much interest. I found the pulse 60, the temperature, 100, and two-thirds of the coating gone. Patient had slept well and said he felt one hundred per cent. better. Had eaten a breakfast, swallowing without pain.

At 8 p. m. the same day the temperature was $100^5$, pulse, 72. Coating gone from one tonsil and slight patch only on the other. Throat not sore; patient feels well and has good appetite. November 29th at 10:30: pulse, 64; temperature, $98^4$. Swelling of glands in neck disappeared as was the coating and swelling of tonsils. Patient feeling perfectly well and eating good meals. November 30th, Patient up and dressed and well. December 4th, culture from throat showed no bacilli and the quarantine was raised. In two days thereafter the young man returned to his office. No man who will believe my statement can doubt this a moderately severe case of diphtheria. The notes are a copy of the record taken at each visit and the case was completely cured with one dose of diphtheria antitoxin, 3000 units, given high in the abdomen above the umbilicus.

The lesson to be drawn is the great advantage of giving antitoxin early. Just twenty-four hours from the initial symptoms the dose was given and in twenty-four hours more the disease was arrested, and in forty-eight hours more every trace of it gone. In my experience every day delayed in giving the remedy means three days longer in curing the case and a delay of three or four days may often mean the death of a child who might have recovered as did the case just reported had the antitoxin been given within twenty-four or thirty-six hours after the onset of the disease.—(Applause.)

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## DIPHTHERIA AND ANTITOXIN.

C. GRAY CAPRON, M. D.,
UTICA.

Not many years ago our allopathic brethren were busy with their little cans of calomel fumigation, thinking they had discovered the only way to successfully combat this active toxin. Hardly had they commenced their labors when the serum therapy burst forth, rele-

gating their former treatment into the shadowy realm of the past and from this theory developed antitoxin, which to-day is largely used and, if reports are true, with much success.

Yet why do some have such flattering results while others score only signal failure? Our diagnosis being correct, if the claims are true, why should this much vaunted specific ever fail? Why should more cases of post-diphtheritic paralysis follow its use than by other modes of treatment, and what has it actually accomplished over an honest, rational, homœopathic regime.

That more cases of paralysis do occur can be verified by the fact that the Clinical Society of London say that the effect of the use of antitoxin upon the frequency of paralysis following diphtheria should theoretically be a lessening of this sequel, because of the diminution of severity and duration of the disease; also the antidotal action of the remedy upon the toxin. Yet in the report of this Society the occurrence of post-diphtherial paralysis in twenty-nine and nine tenths per cent. of the cases in which antitoxin was used stands in unfavorable contrast with its occurrence in only ten and eight tenths per cent. of cases treated by other methods.

The question now arises, Do we accomplish more harm than good by this mode of treatment? Does the large per cent. of sequelæ justify us in its use? Does it seem good practice to attempt to cure a disease by overloading a system with toxins already saturated by a virulent poison? And it seems overloading when so-called competent authority insists that we use from two to one hundred and ten thousand units for a given case.

Gentlemen, I stand before you and say that I am honestly in favor of anything that will cure this dangerous disease. I am not hide-bound nor dogmatic. I have used antitoxin on several occasions, both in the nasal and laryngeal varieties, its special sphere, using a reliable preparation, using it early and in the prescribed dose, yet in the face of masses of favorable testimony I cannot see where it influenced the membrane or general condition of my patients in the least degree. Fortunately I used the indicated remedies, sprays, gargles, medicated air and stimulation, the cases gradually recovering; but as for the membrane being arrested in twelve hours, receding in eighteen, practically gone in twenty-four without other medication and the cases well in three or four days, it certainly was not my good fortune.

The argument may be used of an incorrect diagnosis, but in most cases cultures were made showing beyond a doubt the exact nature of the trouble, and I am honest in my belief had I not used my remedies internally, externally and locally the cases would not have recovered.

It is also a fact that in the past five years there has been a greater decline in the death rate of other infectious diseases than diphtheria, against which no new remedy has been directed. This is certainly a decided point against the specific action of antitoxin.

How unfortunate it seems that the rank and file of the medical profession should be so extremely gullible, reminding one of a flock



of sheep, where, if one gets safely through an opening the rest are sure to follow, entirely heedless of consequences or of what may be the condition on the other side of the aperture.

Of the many accidents or bad results of antitoxin little is said, yet many are known notably of which are enlarged glands, urticarial rash, pain and swelling of joints, simulating rheumatism, neuritis, cloudy swelling of the kidney, degeneration of the heart muscle, increased diphtherial paralysis, and death.

During the past year I have treated a number of cases of these paralyses, patients coming to me from old-school physicians, each having had the antitoxin treatment.

One was a case of paralysis of throat muscles and vocal bands, cured by gels. and caust. Another, a partial paralysis of muscles of arms, limbs and throat. Staggered when walking, deglutition very difficult, arms used imperfectly, with no ability to grasp or hold things in the hand. Gels. cleared up this condition. A third simulated epilepsy. Could feel a peculiar sensation ascending the limbs. When it reached the knees the little fellow would fall unconscious, become rigid and cyanosed. Did not, however, bite his tongue or froth. This condition lasted from one to four minutes and these so-called "spells" occurred from once to fifteen times per week during the past five years. For three months he has been on gels. and secale, having had but two attacks during this period, those taking place the first month of treatment. While this cannot yet be called a cure it is a vast improvement over his former condition.

Now, the first point I wish to convey is that each case was given antitoxin with the result of a paralytic condition, this being in accord with the findings of the London Clinical Society in which nearly three times as many sequelæ of a paralytic nature followed the use of antitoxin than by any other method, and that the after-treatment for this result by allopathic physicians was manifestly incompetent and of no avail.

Is it wise, and are we justified in using a remedy that is so apt to cause conditions more pitiable than the disease for which it was intended to cure? It seems unfortunate that we, as members of the homœopathic school, have such meager statistics of our own from which to draw conclusions. That antitoxin has reduced the old-school mortality seems evident, yet I am not prepared to admit that even now they rival our own. In fact, I have positive data from many of our physicians of from twenty to thirty years' experience whose mortality ranges from nothing to five per cent. and they have never given a single dose of antitoxin; a most favorable comparison against the sixteen per cent. which adherents of antitoxin admit is their best average.

In looking at this question from its broadest view it would seem that the following conclusions present themselves:

That antitoxin has apparently reduced the allopathic mortality from forty to sixteen per cent., yet in doing this they have increased the post-diphtherial paralysis from ten to thirty per cent., that it is not in any sense a specific; that it may be useful in a certain class

of cases, yet positively detrimental to many; that more complications follow its use than by other methods and that the homœopathic school has little if any use for this innovation for the medical treatment of diphtheria.

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## DISCUSSION.

H. L. WALDO, of Troy: *Mr. Chairman,* I would like to ask Dr. Capron if he had had an extended experience with diphtheria previous to the use of antitoxin—if he had treated several hundred cases without antitoxin.

DR. CAPRON: No, Doctor, I had not.

DR. WALDO: It makes a great deal of difference, in my opinion, whether a physician had treated diphtheria before antitoxin was introduced or whether he had not.

DR. CAPRON: I treated cases before, Doctor, but not several hundred cases.

DR. WALDO: I have treated a great many hundred cases of diphtheria, and at the present time there is only one thing I know about it, and that is antitoxin. There is no other remedy I know of that is of any value. Previous to the introduction of antitoxin I had lost scores of cases, and I had tried all kinds of treatment, and had come to the conclusion that we had nothing with which to combat it. Since the introduction of antitoxin—and I want it distinctly understood that I do not make this statement in a boasting spirit, but it is the truth—I have seen no deaths from diphtheria, and I have treated some desperate cases, some cases that, in my opinion, would have died under any other method of treatment, cases in which intubation has been necessary, cases that were cyanosed when they were first seen, and these cases have all recovered. It seems to me that a man can only speak from his own experience, and my views of antitoxin are based not upon reading, but upon bacteriological study; not upon theory, but upon my own experience in the city of Troy and vicinity. If a member of my family were sick with diphtheria I would give all the money that I had and all that I could borrow, if necessary, to get a single dose of antitoxin to administer. It has been asserted that antitoxin is a poison, and that its injection into the human body is apt to be followed by serious results. I have seen no harm follow its use. I had one case in which a rash developed a few days after antitoxin was used, but this rash subsided in a few days and no further symptoms resulted. It has been asserted that the percentage of cases of post-diphtheritic paralysis is larger under the treatment by antitoxin than under other methods of treatment. From my reading I judge that this is so, though I have seen no cases in my own practice following antitoxin. I have repeatedly seen it under former methods of treatment. The explanation has been given, and I think it is the correct one, that under treatment by antitoxin many cases recover that formerly would have died, and, as they are the most severe cases, a certain percentage of them have post-diphtheritic paralysis. Is not a live child, with post-diphtheritic paralysis, from which recovery is the rule, better than a dead child? My advice would be: give antitoxin promptly, and in doses of from 1,500 to 3,000 units.



DR. MARTIN: I have not treated several hundred cases of diphtheria. I have treated a few in the last dozen years. I have seen some of them die without antitoxin, and I have seen a fair percentage of them get well without it. Possibly eighty-five to ninety per cent. of my cases have recovered without antitoxin. I use what I call the indicated remedy, as near as I can get at it, permanganate of potash gargle, and sometimes listerine, sometimes electrozone, and they do fairly well, without any post-diphtheritic paralysis. I have never had a distinct case of post-diphtheritic paralysis that lasted beyond a very few days; and I have seen quite a number of cases in consultation where antitoxin has been used, and I do not know that the results where I have seen it have been any better, and I do not think they have been as good, as my own experience has led me to believe. I have a lot of friends who give antitoxin, and give nothing else, and they get results; but until my results are worse than they have been in the past few years, I am going to stick to what has carried me along fairly well with a reasonable sort of income and a reputation at home for not using antitoxin. I have got quite a number of cases the last year because I didn't use it.

T. FRANKLIN SMITH: *Mr. President,* I cannot say that I have had a very extensive experience in the treatment of diphtheria. I am free to confess that I have never had but very few cases in my entire practice of over forty-one years. I do not think that I have had in all that time more than ten or fifteen cases altogether of real, genuine diphtheria; but I have had a very large number of spurious diphtheria, or of what might be called "diphtheritic sore throat", but which lacked the true diphtheritic element. I know that these cases are very frequently called true diphtheria by many of our physicians, and that is the reason they claim to have treated so many hundreds of cases of diphtheria. I have never yet lost a case of diphtheria. I have never yet been obliged to resort to the use of antitoxin, but have always treated my patients with the single homœopathic remedy. I do not mean to say that I never will resort to the use of antitoxin. My practice is to cure my patient if I can possibly do so, and I am going to cure him with homœopathic remedies if it is a possible thing. When I find that my homœopathic remedies fail, then I will give the next best thing that I know of. But, as I said, I have never yet lost a case, in the few cases of true diphtheria which I have had, and I have never given anything but the single, indicated homœopathic remedy. I remember one case especially in which I was very much interested, and in which I saw the unmistakable action of one remedy, and that given "high", and only one or two doses. The patient was a little girl about ten years of age, whom I was called in to treat, some thirty odd years ago; a poor family, living upon the rocks in Harlem. For two or three days I had been unable

to diagnose precisely just what the disease was; but I went in to see her one afternoon about six o'clock, and then there was no mistaking what the disease was; the odor was very clearly perceptible all over the room; the house was a little shanty. The posterior nares and the larynx were completely covered with the diphtheritic exudation; the child was breathing very heavily, and I was, I must confess, at my wits' end. It was the worst case that I had ever seen. There was no time to look up or study the case very carefully, but to my mind the whole group of symptoms was a clear, well-defined picture of lachesis; I gave lachesis, 200th, and went away; when I returned the following morning, scarcely expecting to find the child living, I found that soon after I left, after the patient had taken the second dose of the medicine, that the entire membrane had come away, and the throat was entirely free from any diphtheritic exudation whatever.

DR. BIRDSALL: It seems to me, Mr. Chairman, that we as homœopathic physicians can learn a very valuable lesson from these two papers and also from the testimony that comes to us along the line of the use of antitoxin in the treatment of this disease, diphtheria. In a practice extending over a period of about thirty-five years I have treated a good many hundred cases of diphtheria in all its forms, and with a death rate not exceeding ten per cent., and I have always relied upon the properly indicated homœopathic remedy; and in the severer forms of diphtheria I want to corroborate Dr. Smith's experience with his cases, that lachesis was more frequently indicated than any other remedy within my knowledge. Now, it is a very singular thing and a very significant fact to us, that in the same allopathic journal, you will find two articles on antitoxin, one lauding it to the skies, and another condemning it from the word go. Both from members of the allopathic profession of equal prominence, men of about like experience, and what are we, as intelligent physicians, to conclude from this sort of thing? It goes without saying that we must accept the testimony of both of them. I believe antitoxin is a compound, and in that sense it is a drug, and it may be that there are some forms of diphtheria to which it is particularly and homœopathically adapted. I believe Dr. Martin Deschere, in a paper read before this Society several years ago, brought out the fact that from an observation extending over a long period of time, and a very great deal of study of the matter, he had come to the conclusion that there was one form of diphtheria to which antitoxin was peculiarly applicable and homœopathic, and that, fortunately, was the most fatal form of the disease, namely, the laryngeal form, where it extends into the larynx and the tubes. Now, I think that in the study of this drug we are going to get some knowledge in connection with it after a time. I think there is a class of cases to which it is peculiarly adapted, and when men come before us and give us their experience on that line, I think we should listen to it. It means something, and we should get all the knowledge and information we can out of it; but that antitoxin is a specific, or any other drug on the face of the



earth, in every case of diphtheria, I do not believe. (Applause.) Our mortality under homœopathic treatment, so far as I have been able to observe, has been almost wholly confined to the cases that infected the larynx. Those are the cases that are most intractable and the hardest to cure; and while my experience in the use of antitoxin is almost nil, if I had a case to-morrow that was advancing and invading the larynx, and had refused to yield to homœopathic remedies, I should certainly use antitoxin.

DR. GARNSEY: *Mr. Chairman*, this seems to be an experience meeting, and I would like to add mine. In Gloversville we are not particularly subject to diphtheria, but in a practice of twenty-two years I have had a little experience with it. Prior to the use of antitoxin I cannot give you the number of cases treated by me, but I will say that I had a mortal dread of the laryngeal form, and when I met a case of what we called in those days membranous croup or laryngeal diphtheria, I had very little hope. I lost quite a good many cases in those days. I cannot give you the proportion. As to paralysis following diphtheria without the use of antitoxin, I had three very marked cases, and two of them died. In one of them, one week after the throat was perfectly well, cardiac paralysis followed, and the patient in a few hours departed this life. Another one had paralysis of the circulatory system, with general dropsy, and died some six weeks after the diphtheria. One of them was sick all summer, unable to work, through the paralysis, and finally recovered. But my experience with antitoxin has been this: since beginning to use it I have treated twenty-six cases. Three of them were laryngeal; one of them was intubated; the other two did not require it. I have had no serious case of paralysis and I have not lost a single patient out of those twenty-six cases treated with antitoxin. My experience, therefore, is decidedly favorable to antitoxin. (Applause.)

DR. MOFFAT: *Mr. Chairman*, it was these experience meetings here that broke down my prejudice against antitoxin. I did not use it for years after I had known of it, and I do use it now, but I do not know that my use of it is of any value to you because I use remedies with it. I do not think I have quite enough confidence in the antitoxin to use it alone. When I find the medicines I can best use not working satisfactorily, I certainly will go to the antitoxin; but if I had had Dr. Gorham's case I would not have waited six hours to make up my mind or to get my remedy. I would have given cyanide of mercury. (Applause.) I believe it would have cured, and I do not question that the antitoxin cured. There are other things in the world beside homœopathy: I do not believe antitoxin is homœopathy, and I am satisfied that antitoxin is not a drug in the sense of being a poison; our Brooklyn attempt to prove it satisfied me of that. I am also satisfied that in many of the cases of antitoxin administration, the antitoxin is poisonous because it is not pure; it has spoiled. There is where we are to blame in the use of antitoxin. We must be more careful of the individual specimen of

antitoxin than with many of our other drugs. The discussion on vaccination to-day shows us the importance of being sure of the preparation. My last case of diphtheria, a few weeks ago, received antitoxin—3000 then 2000 units—but died. The case was getting along very nicely; not brilliantly, the symptoms and the exudate did not disappear like magic, but I was not anxious, although there had been a weak heart, which was getting better. All of a sudden the patient died with cardiac paralysis. I have seen that happen without antitoxin; it is not fair to say the antitoxin did it.

DR. LESEUR: *Mr. Chairman*, I should like to inquire of the writer if he would advise, assuming the wisdom of the use of antitoxin, any physician to wait six hours after having made a diagnosis of diphtheria, before using antitoxin. My opinion is that antitoxin, if used at all, should be used the instant a diagnosis of diphtheria is made, and that if error is to be made in the time of using it, it is better to err in using it when you suspect the diphtheria, even before you are satisfied that diphtheria actually exists, than to wait one fraction of a moment, to say nothing of a fraction of a day before deciding to use antitoxin.

CHAIRMAN WARD: I want to add one little experience we had with antitoxin. I believe antitoxin is a virulent poison, and possibly this experience may be of some aid to some one here, especially the surgeons. The case I wish to mention was one of a lady who was suffering with appendicitis. The best surgeons of our school, or of any other school, were called to see her. I do not know just how long, but a few days previous to that she had been injected with antitoxin to prevent diphtheria. Her little child had had it in the house; was getting over it very nicely. She was taken away from there, every precaution was used that was possible, in every way. Nothing more could have been done, seemingly. She was operated on for appendicitis. No pus at all to be found. Technically that operation was beyond question. No man could have operated nicer. I think this was Thursday. Sunday morning I was called to see the patient in counsel, and found her virtually dying. We communicated with the New York surgeon who had operated her and dressed the wound immediately. Opened it up. It hadn't healed a particle. The skin tissue opened up just like an old dead clam; all blue along the edge; hadn't begun to heal; it hadn't even come together at all, in any way. She died that afternoon in spite of everything that could be done. It seemed to me to be strictly a case of systemic poisoning, and I believe, as I believe nothing else, that that systemic poisoning and death were due solely and absolutely to antitoxin being used. Now, that is not saying anything against antitoxin in diphtheria. It is simply saying that if antitoxin has been used as a preventive, it might be well for surgeons to take that into consideration when they do any laparotomies, or abdominal sections, etc.

DR. MILBANK: I have had some little experience with diphtheria, Mr. Chairman. We had an epidemic here about eleven years ago,



perhaps twelve. Dr. George Cox and I treated all our cases together. We used nothing but the ordinary washes for the throat, to get it cleansed—peroxide, lime water with lactic acid as a spray, and sometime nitric acid, diluted, internally. But our principal remedy was cyanide of mercury, 2x, and in large doses, five and ten grains, every three hours until it produced the toxic effect. We had twenty-five cases of well-marked diphtheria. We had probably seventy-five or one hundred cases that were not so well marked. Still they were all called diphtheria. We saved twenty-one out of the twenty-five with the cyanide of mercury, cases in which the discharge from the nose would run down on the lips, producing sore faces, sore lips. And one case we lost was a boy ten years old. The father did not wish to spray his throat because it hurt him, and he wouldn't give the medicine because it tasted bad. Another was a deaf mute child that was better dead than alive. We had to pry the mouth open to get the medicine in. Another was a case of paralysis after the child had got around the room. We, of course, knew nothing about antitoxin in those days, but I have used the cyanide of mercury from that day to this, 2x. 3x doesn't seem to have any effect; and I give it in large doses. I never had any occasion to use antitoxin but twice, and both cases died. Perhaps I did not use it early enough in the first case. In the second case it was used immediately, and the child died. Five cases in adjoining houses, not my cases, antitoxin was used in one, which was saved. In the other three antitoxin was not used, but cyanide of mercury was used vigorously, and they recovered.

DR. VAN CAMP: *Mr. Chairman*, I would like to ask why we should not use, in the homœopathic school, the indicated remedies instead of remedies that have not been tried or proven. If there is any proof than antitoxin is homœopathic, then use it. If not, I would like to know the reason why we should not use the indicated remedy in preference to the other.

DR. TERRY: Diphtheria, as I look upon it, Mr. Chairman, is a microbe disease, and I do not think we will differ materially in calling it that. When I hear of a man curing a case of diphtheria, therefore, a microbe disease, with 200 lachesis, it makes me sick. (Applause.) And, therefore, I could not resist the temptation, although this subject has been pretty well discussed, to get up here and give vent to my feelings as to a theory that is unscientific and dangerous to allow to go in the press. The only excuse for it is the extreme youth of the gentleman who presented that report. (Laughter.) I do not think an individual experience in the use of antitoxin is quite sufficient. If you will look at the report of Lenox Browne, contained, I think, in Gould's Annual, you will find that he collates about 10,000 cases, and you will find just such reports as Dr. Capron has presented in his very able paper here—and I do not think it is particularly satisfactory. I have not had a large number of cases of diphtheria for years, but I have not lost cases for years. I must confess that my treatment is mongrel. It is not

allopathy, it is not homœopathy. It is antiseptic. If I gave it to you I presume I would be called a mongrel. But it is antiseptic absolutely. If antitoxin does any good at all it is probably in destroying the ptomaine poison produced by the action of those germs on the tissues of the throat. I do not think it kills microbes. I do not think that 200 lachesis will kill a diphtheritic microbe. Does any man here believe that trash?

MEMBER: Yes.

DR. TERRY: Thanks. I should be very glad to tell you how I treat diphtheria. I depend largely upon sulphurous acid. I think you will all admit it is one of our best remedies in cases of germ disease. I give it in the form of a prescription—you may call it old-school if you like—but the combination takes in tincture chloride of iron, chlorate of potash, sulphurous acid and glycerine—you can give these in your dose as you wish. In each dose you will get about ten drops of sulphurous acid and ten of tincture of iron, but you can make the dose smaller if you are treating children. That combination is given once in three hours. Locally, I keep constantly on the throat—I would not take a case unless I had a nurse who would do it—an application composed of sulphur and glycerine, and I have even added trypsin to it, and sometimes I would put on peroxide of hydrogen; the point being, if you can put the diphtheritic microbes at rest you will prevent the poison being absorbed in the system and your patient dying of septicemia. If you can kill those germs the patient won't die, and you won't have paralysis. Moreover, this treatment is peculiar in this respect: it is a tonic treatment, and when your patients are over the diphtheria, and they will be over it in a week, and often within five days, they will not be anæmic and pale, but they will be as strong nearly, as though they had not been sick at all. But the night and day treatment is absolutely essential. If you treat your case through the day time, and allow it to go one, two or three hours, it will surely gain on you. The application, therefore, and treatment must be made every fifteen minutes, and every half hour or hour as your patient gets better; and by that method I have not lost a case of diphtheria in over fifteen years. I recollect an article years ago, published, I think, in the *Medical Times*, on "Night and Day Treatment," and that was the principle used, the point being not to allow these microbes to make any advance and get down to the larynx; and then in the room or house have a bromine solution, one to sixty-four, putting an ounce in a receptacle, with water, and allowing it to evaporate. It will permeate every molecule in the air, and is certainly one of the best antiseptics we have.

DR. MARTIN: We all believe in the germ theory of disease, and we all believe in the "cell doctrine." In order for a man to swallow a pill he has got to have a pill smaller than himself. In order to kill the microbes of diphtheria in a rational manner, you must give them a dose that they can swallow and die a decent death. Dr. Smith gives a potentized dose that they can get around and assimilate, while



Dr. Terry hits them on the head with a club. They die ultimately. (Laughter.)

DR. SIMONDS: *Mr. Chairman*, if we find a pane out of the window it doesn't matter whether it was knocked out with a boot or a stone—we know what the remedy is. If we find an inflammation of a mucous membrane, I do not see anything irrational about applying our remedies to reduce that inflammation, even though the microbe be dead. I have had some experience in the treatment of diphtheria, and in the section where I live we have had diphtheria, and diphtheria. We have had it where people would die and decompose in forty-eight hours, and I think that I have been able to determine from the appearance of the inflammation produced by the condition, pretty nearly whether I had a malignant case or a benign case. I have seen patients die that have been treated with antitoxin, but I thank God for antitoxin. I do not see any reason why we should wait until we know something else will fail, when we know we have a sure and efficient remedy. I believe that antitoxin, if used early, is a sure and efficient remedy for diphtheria, and I believe in using it early.

DR. MOFFAT: I understand that Dr. Terry believes sulphurous acid has certain effects, and he gives it strong enough to get those effects, a material dose; that chloride of iron has proven itself a benefit in such cases, and so he will give that; and the chlorate of potash has proven of benefit, and he will give that. It isn't any of their business to act upon each other; he wants them to act upon the human body, and to pay no attention to one another; of course, they comply with his wishes. My studies in chemistry led me to expect chemical changes in these drugs when brought together in one solution. The old school very generally abandoned this treatment years ago for antitoxin from which they claim to get better results.

DR. TERRY: *Mr. Chairman*, I am perfectly willing to answer my friend, Dr. Moffat, every time. I do not care anything about Dr. Moffat's chemistry. It doesn't make any difference whether his chemistry is out of date or not, I know about the results I get. I forgot to mention that mercurious cyanide is a good remedy, and it is a good remedy because it is antiseptic. You know it because it acts destructively upon these microbes. I do not care what Dr. Moffat says, or whether these remedies are in harmony or not, I know they do act in harmony, and I know I get my results. That I am positive in regard to. If Dr. Moffat gets results with the two hundred millionths of nothing, I am perfectly willing he should, but I say this disease must be treated chemically to a certain extent to kill the microbes located in the throat. If you don't do that you get, in the words of Sam Jones, a "stink," which is decomposition, from the action of these microbes on the animal tissue. Now, you destroy that. After the first visit to the patient there is no odor of any kind, and I know that after my first visit that patient cannot communicate a case of diphtheria even to a child, simply because I have thoroughly purified that throat, as I do in a case of surgery; I have had a nursing baby right in the same room without having taken

the disease. I am sorry, of course, for Dr. Moffat's chemistry, that it is in such a delicate state that he cannot twist and prove the remedies the same as I can, but I know I can do it. (Laughter.)

DR. GREENLEAF: Dr. Herbert D. Pease, Director of the Antitoxin Laboratory of the State Department of Health, is here and will speak to us on antitoxin.

DR. PEASE: *Mr. Chairman and Gentlemen.* There are a number of things that I might talk about, but it is getting late. Probably I am as young as any man here, and probably I have had as much experience as any one present with diphtheria. Not, however, in human beings, but in horses and guinea-pigs. Speaking from considerable experience I can safely say that we do not yet know all there is to be known about diphtheria, nor its organism. I have killed horses with an amount of toxin produced by the diphtheria bacillus that is hardly measurable. Other horses will stand 100 times that dose of the same toxin without being affected more than to have a slight local œdema. Undoubtedly there is more than one poison in what we call diphtheria toxin. We know that there are at least three or four, and they differ very materially in certain of their poisonous properties. Ehrlich, one of the greatest workers on antitoxin that the world has ever seen, thinks one of these poisons is especially productive of paralysis. Whether there is created in the horse an antitoxin which will neutralize each and every one of these poisons, we are not as yet prepared to say. There are many things, infinitely many things, yet to be learned about diphtheria antitoxin and also about the organism and the poison which it produces. That antitoxin is a specific for certain poisons produced by the diphtheria bacillus is just as absolute as anything possibly could be. We can measure the accuracy with which we can neutralize these poisons of diphtheria with their antitoxin just as accurately as you can count up a column of figures. Just as uniformly as a guinea-pig inoculated with what has been previously determined to be the minimum fatal dose of diphtheria poison dies from such an injection, just so definitely can that dose be neutralized in the guinea-pig with a definite amount of antitoxin. That operation has been carried on in thousands of instances on guinea-pigs, and is absolutely without question. But we use on that guinea-pig an antitoxin which has been produced in the horse by a toxin of the same kind and nature as we inject into the guinea-pig. With these poisons we produce a remedy which will neutralize these poisons. We do not say, however, nor is it at all probable, that all the diphtheria bacilli which cause disease in human beings have the same powers of producing the same poison in human beings that we are using in our production of antitoxin. Here, then, is a point which may explain, to a certain extent, the somewhat varying clinical results. Of course, all these points have yet to be worked out satisfactorily. Ultimately they undoubtedly will be. At the present time we have to take things as they are.

Now, as to the antiseptic treatment of diphtheria. Undoubtedly that treatment ought to be carried on just as regularly as the injection of antitoxin. That we should give up one remedy because we have another, is absurd. We should undertake the antiseptic treatment of the throat vigorously, and any remedies of any kind or description which will in any way benefit the general system should also be used as well. However, the absolute destruction of diphtheria bacilli in the throat is impossible. Cultures taken from the throat shortly after the application of some disinfectant may fail to show their presence, but such results are not permanent, and subsequent cultures usually reveal their continued presence. I can say from long experience and the general consensus of opinion among laboratory men is that it is impossible to destroy the diphtheria bacilli in the throat with disinfectants. But there is no doubt that such disinfectants do exert a very beneficial effect. We have not yet fully ascertained the effect of such chemicals on the poison produced by the diphtheria bacillus. We know for a fact in the laboratory that if we add large quantities of carbolic acid to diphtheria or tetanus toxin, the power of that poison to kill guinea-pigs is tremendously reduced. If we add formaldehyd to it, it almost entirely disappears. There has been a rational treatment of tetanus instituted by the injection of carbolic acid. No one supposes for a moment that it has any effect on the organism. It would be given in far too small quantities to have any effect on the tetanus bacillus, but that it does neutralize the poison in some way is unquestioned. I have cured a horse of tetanus by simply injecting formaldehyd under the skin. I should not care to institute such a proceeding in a human being. It would be too severe a treatment, as the formaldehyd is exceptionally irritating. So the antiseptic treatment of diphtheria is undoubtedly of great benefit. One of the best mixtures I know of for that purpose is the following:

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| Menthol, | 10 grms. |
| Toluol, q. s. | 36 c. c. |
| Alcohol Absol., | 60 c. c. |
| Liq. Ferri Sesquichlor, | 4 c. c. |

It has to be applied very carefully. The fumes of the alcohol produce a choking sensation, but the effect on the membrane is something marvelous. Within the last few days I have read of very fine results obtained by the use of formaldehyd, two to four per cent., mixed in glycerine. That does away with the excessively irritating effect of formaldehyd, but at the same time produces very marked beneficial effects on the membrane. Formaldehyd is unquestionably one of the most highly toxic materials for bacteria that we know of. At the same time it is one of the least poisonous to the human cell. A fatal dose of formaldehyd for a human being is about twenty-seven grams, which is an excessively large amount, considering that less than a grain of the bichloride of mercury would certainly be fatal. What has been said here in favor of the use of antitoxin, I, without hesitation, endorse. The time of giving it is, of course, of the greatest importance. The earlier it is administered, the more favorable are the results obtained by its use. Some common laboratory experiences demonstrate the reasons for this. I give a guinea-pig ten absolutely fatal doses of diphtheria poison. Does he die at once?

No. He may live twenty-four hours; he may live thirty-six hours, and then he will go right down. In the meantime, if you were to examine that guinea-pig, you would hardly know that he was diseased. It takes time for the results of the activity of these toxins to appear, and before the symptoms you or I would notice are produced some serious injury may be done to some delicate cell elements in the body, and very possibly diphtheritic paralysis is brought about in this way. The paralysis is quite possibly due to the early toxic effects of the poison of the diphtheria bacillus, and damage once done will not be remedied by antitoxin, nor antiseptics, nor any other treatment which we can institute under those circumstances. We can only antagonize the antitoxin that is in circulation in the general system and prevent any further elaboration of the toxin by the organism in the throat. This may explain the poor results obtained by some from the use of antitoxin and the large number of cases of paralysis, for instance, that have been cited as occurring in London. In the large hospitals they rarely see cases of diphtheria before the third, and often not before the fifth and sixth days of the disease, and during that time it would indeed be strange if some serious damage had not been inflicted on the nervous system of the patient by this toxin. We know for a fact that toxin produces great changes in the ultimate endings of certain of the nerve fibres, and it would indeed be strange if after two or three days of the most severe poisoning some actual lesion had not taken place which could not be cured by the introducton of any remedy. We cannot neutralize damage that has already been done.

Now, I want to explain what the State Department of Health has undertaken. We received last year an appropriation of $20,000 from the Legislature to manufacture diphtheria and tetanus antitoxins, also to carry on experimental work along these same lines. The diphtheria antitoxin has been produced in the laboratory, and within a very few weeks we will be able to send out our first installment of the remedy. The antitoxin is designed for use on cases that cannot afford to pay for it. We are not in competition with commercial houses in any sense. We merely intend to allow a practitioner who desires to use antitoxin to obtain enough of it so that he can use it in proper doses on people who are unable to buy it for themselves. The antitoxin will be distributed to the various local health officers, and can be obtained by any physician upon signing a receipt stating that he is to use the remedy on such cases. It will be the endeavor of the department to keep as much on hand in the hands of the various health officers as the population of the region will warrant. In the larger cities we propose to keep quite a large stock in the hands of the local health officers. Inmates of charitable institutions, of State institutions conducted on a charitable basis, and all individual charity cases will be eligible for treatment with the antitoxin furnished free by the State of New York. We will continue to do this just as long as the Legislature gives us the necessary funds. (Applause.)



# URICACIDEMIA.

BY CHAS. A. GWYNN, M. D.,
AUBURN.

Uricacidemia, strictly speaking, the existence of abnormal quantities of uric acid in the blood. By common consent the abnormal existence of uric acid in the different tissues of the living body.

It is not my wish to enter into the various theories as to the primal origin of this acid. Whether uric or lithic acid is at times abnormally evolved and at the same time not proportionately excreted. Whether it is at times more readily produced because of a decreased alkalinity of the blood and secretions, or whether, as seems most probable, its existence is due to inherent, morbid tissue metabolism plus a neurotrophic disturbance. These considerations do interest us, not alone that the discovery of the initial point may aid us in prevention but because as clinicians we are interested in the group of symptoms near at hand and the diseases more remote which are clearly traceable to an excess of uric acid in the body.

The origin of uric acid in the liver seems hardly tenable because the hepatic vein at its exit from the liver contains no more of the acid than does the portal vein on its entrance into that organ.

The spleen contains much uric acid and as the return blood from that organ passes next to the liver, the liver is, therefore, privileged to hold and distribute that salt without being responsible for its production. Uric acid in the blood is not a disease per se, but it represents the ineffectual attempt of the organism to oust a poisonous intruder.

In all probability the urinary excretion of uric acid is carried on by a selective power of the epithelial lining of the tubules just as the salines are excreted by the glomeruli.

The origin of lithic acid is in the tissues themselves and due to the faulty oxidation of proteid substances.

Failure of the renal function usually precedes the development of uric acid manifestations and is largely productive of the symptoms of lithemia.

Rheumatism and gout we have often met and both these diseases are dependent on a lithemic condition plus certain separate and individual causes which serve to distinguish them from lithemia and from each other.

Lithemia is a comparatively latent condition and the excess of acid salts may be carried off for a long time before the symptoms of the difficulty attract attention. But, to quote Dr. DuCosta, there is a time when the income of nutriment exceeds the output of waste and the manifestations of uricacidemia are the result.

The symptoms are most prominent in the nervous and gastro-intestinal systems. The nervous symptoms are headache, neuralgic

twinges, sciatica, tingling, itching and burning in the skin, asthma and certain mental conditions as insomnia, irritable temper and the blues.

The gastro-intestinal symptoms are impaired and variable appetite which is sometimes perverted; tongue coated, digestion impaired with pyrosis, fullness and oppression in the region of the stomach.

When faulty conversion of the albumenoids exists belching of gas follows immediately after meals, but when conversion of the carbohydrates is most at fault the flatulency is most marked in the bowels and appears some time after eating.

The bowels are usually constipated, although occasional storms of frothy, bad smelling diarrhœa may alternate with the constipation in nature's attempt to excrete the effete and poisonous accumulations.

The arterial tension is high and may be accompanied by palpitation.

Arteriosclerosis is always present in protracted cases and chronic gout and granular kidney are present in later stages.

The liver is engorged and tender. The urine is usually over-colored and of high specific gravity and deposits lithic acid in many instances.

The urinary mucous membranes are easily provoked to inflammations and urethritis, cystitis, orchitis, vaginitis and endometritis are common.

These inflammations are extremely difficult to control until the lithemic or gouty condition common to the organism is radically assailed.

To meet the acute condition of an outburst of lithemia, aconite, belladonna or gelsemium may be needed. Bryonia is more often indicated and more often useful. Berberis acts well on the renal and general condition of lithemia as well as upon the arthritic complication when gout is present.

Whatever attempt is made to remedy the lithemic condition, prophylaxis in the way of diet and manner of living is of first importance.

A life of judicious exercise in the open air, freed from great exposure and dampness, favors improved oxidation and permits greater latitude in diet. In the overfed, meat only once a day and the absence of starches and sugar is advisable.

In the neurotic and anæmic full diet of plain meats and green vegetables assists the establishing of a higher plane of general health for the individual. The indigestion of the lithemic calls for nux vomica, pulsatilla or lycopodium. For the general lithemic condition large quantities of pure water, either distilled water, rain water or that obtained from some spring of recognized purity and freedom from mineral salts. For the solution of the uric acid three remedies are freely employed and are often of temporary benefit, namely: salicylate of ammonia, citrate of lithia and phosphate of soda.

Particular attention must be paid to the bowels; either enemata or mild laxatives aid in flushing the intestinal sewer and the sulphates of soda or magnesia in small doses are of great benefit. When the fevered condition has been relieved and the diet regulated and the skin, kidneys and bowels acting freely, then the cure is not completed or the results made permanent unless careful selection of the constitutional remedy suitable to the patient and his condition is made.



## DISCUSSION.

J. W. CANDEE, of Syracuse: *Mr. Chairman*, I am glad to have so important a matter brought before the Society. It seems to me that the consideration of uric acid and the conditions arising from uric acid poisoning is among the most practical questions with which physicians at the present day are called upon to deal. Anything giving aid to the profession in meeting this situation is certainly desirable. I note one thing in particular with regard to the therapeutics referred to by Dr. Gwynn, that is the use of berberis vulgaris in treating conditions dependent upon uric acid poisoning. It has also in my hands proved to be a very satisfactory and efficient drug. In that connection the thought occurs, how is one to be guided in the selection of berberis vulgaris for uric acid conditions? As you know, the provings are not very prolific and our literature on the subject is not extensive. We are familiar with certain indications for berberis vulgaris referable to the right hypochondrium, pain in the small of the back at the right side extending down over the point of the hip and along the right ureter, certain characteristics of the urine, etc., but in the absence of more comprehensive indications I have come to very often prescribe the drug empirically. I simply prescribe for a condition, prescribe by name, if you please, because in this instance I know no better guide. I have for a long time had in mind the intention to bring up at every possible occasion, such as this, for instance, reference to the necessity for doing work on our materia medica. This matter, as you know, has been before us several times in the past two years but it cannot be too often presented. We, as homœopathists, are obliged to treat drugs, so to speak, unfairly. In other words, we are compelled to use many of our own drugs empirically. I should like to learn this morning if any additional guides for prescribing berberis vulgaris are known and can be indicated.

W. M. L. FISKE: I must say, as Dr. Candee does, that there are some of our remedies that have to be prescribed in just that way, and berberis vulgaris is one of the remedies that I prescribe in that way, not from any particular symptoms or from the symptomatology as given from the proving of the drug, but in its use in this very same class of diseases which we denote as uric acid diathesis; and I find it of eminent service, although I think I have fallen into the way of prescribing it the same as Dr. Candee has, simply from experience in the use of it, and from seeing some article that drew my attention to it in the first place, for these conditions—in other words, prescribing it empirically.

DR. MARTIN: How do you give it?

DR. FISKE: I usually give it in the tincture, five to ten drops.

CHAIRMAN WARD: I would like to call on Dr. Schenck to tell us something about the iritis due to this uric acid poisoning, if he can give us any points on it.

H. D. SCHENCK: The rheumatic form of iritis is undoubtedly most common in this country, and probably has a very close relation to the uric acid diathesis. I have never used drugs, however, in treating iritis that had any relation to the theory that a uric acid condition was the basis for administering them; nor have I observed accurately the urinary conditions, so that I would be prepared to say what proportion of the cases of rheumatic iritis are due to uric acid poisoning to cold *per se*.

CHAIRMAN WARD: What treatment do you pursue when you get this rheumatic iritis? We run across cases very frequently complicated with this.

H. D. SCHENCK: The first and most important thing in treating iritis is to use a medriatic to dilate the pupils and prevent adhesions between the iris and the lens. Quiet for the eyes secured by a bandage and the use of the indicated drugs usually, some preparation of mercury, hepar sulph. or some of the deep acting drugs of that character.

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# REPORT

OF THE

BUREAU OF NEUROLOGY.

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## NEURITIS.

WILLIAM MORRIS BUTLER, A. M., M. D.,
BROOKLYN.

Twenty-five years ago little was known regarding inflammation of the nerves. Since that time neuritis has been thoroughly studied by neurologists of every country and medical literature is filled with cases illustrating every phase of the disease. As a result of these investigations the list of cases formerly relegated to lesions of the cord has been greatly diminished, as many of these cases have been found to be produced solely by changes in the nerves themselves. Many so-called neuralgias and rheumatic disorders, formerly hopeless, when treated as inflamed local nerves have received prompt and permanent relief. The frequency of the occurrence of this disease in general practice is our excuse for presenting it to your consideration at this time.



Neuritis may affect a single nerve, or group of nerves, or appear as a multiple neuritis, in which there is general inflammation of all the peripheral nerves. According to the location of the inflammation in the perineurium, the connective tissue between the nerve fibres or in the nerve fibres themselves it is known as perineuritis, interstitial neuritis, or parenchymatous neuritis.

Simple neuritis is usually caused by injuries, wounds or some compression of the nerve trunks. Fractures and dislocations frequently set up an inflammation in the nerves in the immediate neighborhood of the injury. Extreme muscular contractions or too prolonged excessive use of the muscles may produce it. Extreme cold is a frequent causative agency. Gout, rheumatism, cancer, syphilis, diphtheria, small-pox, typhoid, pneumonia, pleurisy and meningitis have in numerous instances played the part of predisposing or exciting causes.

According to the severity of the disease the pathological changes range from a simple reddening and swelling of the nerve, with distention of the blood vessels, to a complete disintegration and disappearance of the myelin and axis cylinder, leaving only an empty collapsed sheath of Schwan as a connective tissue strand and rendering necessary a complete rebuilding by the process of regeneration of the entire contents of the nerve sheath before a complete cure can be effected.

The clinical symptoms vary according to the functions of the nerve involved. The first symptom is usually pain in the affected nerve. This pain varies greatly in its severity, but is ordinarily very intense and attended by marked soreness and tenderness along the whole course of the nerve; although there may be remissions during the day it is liable to be almost unendurable at night. The pain may be burning and tearing along the nerve with conspicuous motor symptoms. Paralysis of the muscles supplied by the involved nerves soon intervenes. The degree of paralysis varies according to the intensity of the inflammation, in some cases being attended by partial, in others with complete loss of power. The electrical reactions are altered and soon there is a marked quantitive change to the faradic and galvanic currents. In a short time there is no response to the faradic current and the reaction of degeneration to the galvanic current is then present. Atrophy of the muscles quickly succeeds the paralysis. The skin of the fingers frequently becomes red and glossy and the joints swollen and inflamed, revealing the trophic changes which have taken place. The subcutaneous tissue of the fingers and even the bones may atrophy. The nails become rough, brittle and ridged or the whole nail may be destroyed. In the acute

form of neuritis, in addition to the symptoms enumerated we may have, at times, chills, rigors, headache and slight fever, but these general symptoms do not occur in the sub-acute or chronic varieties.

Multiple neuritis is the condition where many of the nerves are involved at once. It has been divided into various forms classified according to the etiology. We have: First, Toxic cases produced by alcohol, arsenic, lead and bisulphide of carbon. Second, Infectious cases caused by the infectious agents producing diphtheria, variola, typhoid and typhus fevers, severe malarial fever and tuberculosis. Third, Spontaneous cases, in which cold, exposure to damp and wet and over-exertion appear as the causative agencies. Alcoholic multiple neuritis is more apt to occur in females, although males are not exempt. It occurs most frequently among the higher classes who lead an inactive life, when spirituous liquors have been taken in large amounts for a long time. After premonitory symptoms of gastritis, insomnia, general neuralgic pains, tremor and feebleness in the limbs have existed for some time, the legs suddenly give way and the patient is not able to rise. A complete paralysis in the feet and limbs soon ensues and may advance up the thighs. The hands and forearms are next attacked. The loss of power is usually greatest in the extensors, although in some cases both plexors and extensors become powerless. The affected muscles are flabby and soon atrophy, showing no excitability to mechanical irritation and the tendon reflexes are lost. Usually the faradic current produces little or no response and galvanism reveals the presence of reaction of degeneration. Two characteristic symptoms, the dropped foot and dropped wrist appear and more rarely the "main en griffe." With these motor symptoms profuse sweating, lividity, œdema, and a glossy appearance of the skin are associated. The most distressing symptom, however, is the excruciating pain which is present, preventing sleep and wearing out the patient's vitality.

Hyperæsthesia is another frequent symptom. This is usually quite extensive in the legs and may render the muscles and skin so sensitive that it is almost impossible to move or even touch the patient. Numbness, tingling and formication appear and numerous abnormal sensations as if bands about the limbs or a feeling as if bursting. When the paralysis is established the muscular and tactile senses are lost. Temperature, sense and the perception of pain may be delayed but are not entirely lost.

In the beginning of the attack the temperature ranges from 101° to 103° and the pulse is feeble and rapid, ranging from 100 to 150.

The walk is characteristic, as, owing to the foot drop, the patient is obliged to lift his knees high in order that the toes may clear the ground. The special senses are not usually involved.

When the disease is established brain symptoms appear. At first there may be active delirium with illusions, hallucinations and insomnia. Marked loss of memory, especially for recent events exists and lack of power of concentration preventing intelligent conversation. These patients' statements are entirely unreliable and no dependence can be placed upon their accounts of their symptoms.



The symptoms of alcoholic neuritis usually reach their height in from one to two weeks, when, if the respiratory tract is not involved producing death, they usually remain stationary for a time and then gradually subside. The individual muscles slowly regain their normal condition. Permanent deformities from muscular contractions may occasionally remain, necessitating operative measures.

The symptoms of multiple neuritis from lead and arsenic resemble closely those produced by alcohol, but when lead is the causative agent few or no sensory symptoms are present, while in arsenical neuritis the sensory symptoms are more marked, but the mental symptoms seldom appear. Of the forms of multiple neuritis consequent upon infectious diseases, by far the most common is diphtheritic paralysis. This paralysis is more common in the adult than children and is extremely rare in children under two years of age. The paralysis does not seem to depend upon the severity of the diphtheritic attack, cases having occurred when the throat symptoms were exceedingly mild. The majority of cases occur two or three weeks after the termination of the disease.

The part first affected and often the only one involved is the palate, producing nasal speech and regurgitation of liquids through the nose. The next most frequent is loss of accommodation and if the disease progresses involvement of the upper and lower extremities follows. This first appears as simple weakness with tingling and numbness, soon increasing to paralysis with marked disturbance of sensation. The ocular muscles are especially susceptible to attack and various forms of paralysis or disturbance of function occur according to the particular nerves involved. The optic nerve fortunately escapes, so that blindness is not to be apprehended. Frequent paralysis of the muscles of the larynx, vocal cords and epiglottis occurs, producing hoarseness, imperfect phonation and difficulty in swallowing on account of the foods reaching the larynx and causing fits of coughing.

The reflexes are diminished or lost and infrequently paralysis of the pharynx may occur.

The disease usually lasts six or eight weeks, the ocular nerves being the first to recover. In severe cases of paralysis of the legs four or six months may elapse before complete power is restored, the reflexes, in most cases, not being restored until all other symptoms of the disease have disappeared.

Cases of neuritis following variola, typhoid fever, malarial fever and tuberculosis have been reported, but their main features are like those of the forms already described.

Acute multiple neuritis, when produced by a cold, is ushered in with a chill and a rise of temperature to 103° or 104°. There is headache, pain in back and limbs, loss of appetite and general malaise attended by formication and tingling in feet and limbs and general muscular soreness and aching. Loss of power in the flexors of the feet soon appears and the weakness extends upwards. Sometimes the paralysis may begin in the arms and later involve the legs. In severe cases the paralysis soon becomes general, including the trunk and respiratory muscles. Atrophying of the muscles soon takes place,

the deep reflexes are lost early, but the skin reflexes vary, some being lost and others retained. Except in severe cases the electrical reaction may remain unchanged for a long time, the muscles responding normally to the faradic current. The sensory symptoms vary from slight sensations of formication and numbness with hyperæsthesia to marked anæsthesia. Cases vary greatly, in some the motor, in others the sensory symptoms predominating.

The disease may run its course within a week, terminating in death from bulbar paralysis, or may last for five or six weeks, before any marked change appears.

Paralysis, with atrophy and muscular contraction, may last for years, but with gradual increase of the muscular strength.

### TREATMENT.

Whatever the form of neuritis, it is absolutely essential that the nerves involved should have absolute rest. When the inflammation occurs in the upper extremities this can be effected by carrying the arm constantly in a sling, but when the nerves of the trunk or legs are attacked the patient must be kept in bed. The intense pain is usually mollified by the application of heat over the inflamed nerve. Much relief is, at times, obtained by immersing the limb in hot water, and in swathing the part with cotton. Some cases, however, are aggravated by heat and secure the greatest relief from cold applications, even the direct application of ice may be required. Where heat is used care must be taken not to blister the skin, as from its enervated state severe sores may be formed without the patient's knowledge.

When the disease has been caused by alcohol entire abstinence must be enforced or recovery is impossible. The withdrawal of stimulants cannot, in all cases, be accomplished immediately or the patient may succumb to heart failure. Alcohol is, however, a most potent poison in these cases and, although taken in small quantities, may bring back all the original symptoms, when the patient is almost restored.

In all cases it is essential, if possible, to learn the cause and remove this, else all treatment may prove unavailing. The diet must be simple, unstimulating and easily assimilated.

Electricity plays an important part in this disease, but care must be taken as to the form, and time of its administration. If given during the stage of intense pain it may aggravate all the symptoms. When the pain has become modified a mild, constant, galvanic current should be applied to the degenerated nerve, the current being passed through the nerve in either direction, or in both alternately. When atrophy has occurred the faradic current and gentle, carefully applied massage will greatly aid in restoring the affected parts.

The homœopathic remedies which we have found most often curative are aconite, actæa racemosa, agaricus, arnica, arsenicum album, belladonna, bellis perennis, bryonia, hypericum, phosphorus and rhus tox.

ACONITE.—Numbness, coldness, formication. Sharp, shooting,



tearing pains in limbs and joints. Aggravation at night, worse from midnight to 3 a. m. Great restlessness and uneasiness. Pains unbearable, great anguish with moaning and groaning. This remedy has been very efficacious in our experience. Especially indicated in the acute stage when disease has been caused by exposure to the cold.

ACTÆA RACEMOSA.—Severe aching in arms and legs. Numbness as if the nerves were being compressed. Excessive muscular soreness. Muscular twitchings. Trembling of limbs, sleepnessness or sleep disturbed by unpleasant dreams. More often indicated in alcoholic cases than any other drug.

AGARICUS.—Burning and itching of hands and feet which are red, hot and swollen as if frozen. Cramps in hands and feet. Trembling and twitching of muscles of hands and feet. Powerlessness and great weariness. Restless and uneasy. Sleep disturbed.

ARNICA.—Pains in arms and hands, legs and feet. Soreness all over as if parts had been bruised. Especially indicated in traumatic cases.

ARSENICUM.—Burning, tearing pains in limbs. Pains shooting from fingers up the arms into shoulders. Worse at night. Relieved by heat. Swelling of feet and hands. Great restlessness and uneasiness. Especially indicated in severe forms of multiple neuritis.

BELLADONNA.—Intense, almost unbearable, paroxysmal pains in affected nerves. Great sensitiveness of parts to touch. Cannot bear even weight of bed clothes. Sleeplessness. Pains relieved by warmth.

BELLIS PERENNIS.—This has, in our experience, proven more often curative than any other remedy when there is great soreness with intense pain. In cases where arnica seemed indicated, but did no good, bellis perennis has, many times, given prompt and permanent relief.

BRYONIA.—Tearing, piercing, stitching, cutting pains, aggravated by motion. Oversensitiveness of all senses. Aching, cramplike pains. Limbs swollen, red and sensitive to touch. Relief from hard pressure and cold applications.

HYPERICUM.—Especially indicated in traumatic cases where the nerves have been torn and lacerated and the patient suffers sharp, cutting pains along the course of the nerve, terminating in a twisting, wrenching sensation in the foot.

PHOSPHORUS.—This remedy may be needed in chronic cases where degeneration has taken place and its individual symptoms are present.

RHUS TOX.—Tearing, drawing, shooting, throbbing pains with numbness and sense of pressure and loss of power in limbs affected. Great restlessness. Aggravation by rest and cold. Amelioration from continued motion and heat. Especially indicated when disease has been caused by getting wet.

In addition to the remedies mentioned æsculus, berberis, calcarea carb., dulcamara, natrum sulph., veratrum album have given excellent results when their individual symptoms were present.

## DISCUSSION.

DR. FISKE: *Mr. Chairman*, I would like to ask Dr. Butler what remedy he finds most efficacious in the paralysis that follows diphtheria. I think that that form of paralysis appears to the general practitioner more frequently than any other, and as far as the action of aconite is concerned, I think it is one of the most reliable of all the remedies we have in the general curable forms of neuritis. But the form of neuritis that most frequently comes under the care of the general practitioner is the paralysis that follows diphtheria.

DR. BUTLER: *Mr. Chairman*, I do not think there is any one remedy that I can recommend above the others. I think in those diphtheritic cases you have to depend altogether on the parts that are involved and on the general symptoms. You must have a remedy that is pretty deep. In my understanding of the remedies, aconite is an excellent one, but is not so deep-seated as ars. or rhus, or plumbum, or some of the remedies of that sort. You have to depend altogether on the parts that are involved, and I think you have to depend considerably on electricity as well as on the remedies. You must discover the general symptoms and be governed the same as in ordinary prescribing.

DR. PALMER: Speaking of diphtheritic paralysis, and especially of ophthalmic cases, I have found that a combination of zinc phosphide, and gelsemium in others, seemed to give us the best results.

DR. BUTLER: Causticum is one of the principal remedies.

DR. PALMER: Those two remedies I speak of as giving the best result.

DR. BUTLER: There is one remedy that is used for paralysis, not particularly in neuritis alone, that I did not mention here, and that is oxalic acid. I accidentally, unfortunately, saw a proving of oxalic acid which verified all the symptoms ever given in any materia medica and a good many more. A good many years ago one of my suicidal cases, through the carelessness of an attendant, took a pint of oxalic acid, and ended in death. I have used that in a good many of those cases of paralysis with excellent results. Take about the sixth trituration of oxalic acid, in some of those deep cases of diphtheritic paralysis. That would probably be found efficacious, as well as the remedies that have been used.

DR. MOFFAT: *Mr. Chairman*, I was taught years ago that one of the first remedies to use in post-diphtheritic paralysis was causticum, and I have found benefit from it when I got ptosis and drooping of the optic nerve, or when there was pharyngeal paralysis with it. The doctor did not mention atropin. I have had very brilliant results with atropin in neuralgias, and even in some neuritis, though there was some functional neuralgia, I suppose, in it. I would like to ask the doctor what remedy is indicated in a case that a man called rheumatism; pain in the middle of the thigh and middle of the arm, just over the exit of the nerves, relieved by heat and worse in damp weather, with restlessness. I gave rhus but rhus did no good.



DR. BUTLER: I don't know why it is, but I think the cimicifuga treatment has a special affinity for alcoholics, and you may be disappointed in it sometimes when it has not an alcoholic basis; but where it has an alcoholic basis it is almost a sure cure, if you get that symptom of paralysis of the eye-lids. I know I saw a case some years ago that I prescribed it for and it didn't do a particle of good. The case went the round of a number of doctors, and finally Dr. Boyle, of New York, prescribed kalmia, with the most wonderful results, and cured the case entirely, after it had been going on for years. I never could find out exactly what he prescribed it from, but he cured the case all the same with kalmia.

DR. MOFFAT: Ptosis?

DR. BUTLER: Complete ptosis.

DR. MCDOWELL: *Mr. Chairman*, I would like to corroborate Dr. Palmer's statement with regard to zinc phosphide in post-diphtheritic paralysis involving the pharynx and also the ciliary muscle. I used it a short time ago, in a case of ciliary paralysis following diphtheria which had lasted for about four weeks. The child seemed to have an absolute loss of accommodation, and the mother was very much alarmed lest the child would have to be taken from school on account of inability to study. I gave zinc phosphide in the 3x, and the child recovered in a week perfect control of accommodation. I asked the mother when the improvement began, and she said in about three days. Now, there is a bare possibility that the paralysis was passing off at that time, but it was a very pleasing coincidence to me and I made a note of it.

DR. BUTLER: There is one thing you have to take into consideration in prescribing remedies in all cases of neuritis, and that is the condition of the nerve when you prescribe the remedy. If you have a case where the nerve sheath has been entirely emptied, and regeneration has not gone on to any great extent, you may prescribe almost any remedy, and you will have to wait some time before your remedy is going to have effect. If you happen to get a case in your hands when regeneration has been pretty nearly completed, you get results that you otherwise would not. I think nature has a great deal to do with curing many of these cases of neuritis, independent of the remedies, because when you have a nerve sheath entirely emptied, that must be restored by building up, and must be built up before you get a complete restoration. I think that a great many of our phenomenal cures may be due a great deal to nature have gotten the nerve pretty well cured before we begin.

T. FRANKLIN SMITH: *Mr. President*, I hope that our friend from Utica has entirely recovered from his violent attack of nausea, this morning. If he has, I would like to make a suggestion in reply to the question of Dr. Moffat's; it is not especially in the connection which he speaks of, but as a general plan to follow. It has been a practice of mine for a number of years past, when I have found a case which I considered clearly indicated a certain remedy, and where I had prescribed that remedy for some time, in different potencies,

high and low, to stop giving that remedy, and then to give a high attenuation of sulphur, usually 200th, one dose each morning, for three or four successive mornings; after waiting for two days, I then return to the former indicated remedy, and in a very large majority of cases, almost every case, that remedy will then have the desired effect. I do not know whether Dr. Terry has recovered from his nausea or not, but I hope he has, and that he is feeling all right now. If he has not, I would suggest one dose of ipecac, very low, so as to bring on vomiting. (Laughter.)

DR. CHASE: I would like to ask Dr. Butler what remedy he would use in a case of cramps in paralysis of the limb. I have a patient eighty-two years old who has suffered with cramps in the paralyzed side.

DR. BUTLER: I should use cuprum.

DR. CHASE: I have given her cuprum from A to Z for a long time. It has helped at times, and sometimes it would not. The patient would go for a week with no cramps at all and then have them with full force again. Dr. Fiske recommended zinc. valer., 3x. Dr. Butler also suggested the use of bellis perennis. I might add as a sequel to above recommendations, if it is allowable, that the patient has had bellis since, and is much more free from cramps than formerly.

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## ACROMEGALY; A CASE.

MAURICE C. ASHLEY, M. D.,
MIDDLETOWN.

Since Dr. Pierre Marie, in 1885, described acromegalia probably enough has been written on the subject to acquaint the medical profession with this peculiar disease. However, it may be proper to refresh your memories as to the general characteristics of this malady.

The first symptom noticed is usually hypertrophy of the hands. They are broadened, thickened and chubby. The fingers show the same changes; they are compared to sausages, the length of the hands and fingers is not increased. The feet are broadened, though not so much as the hands.

The face is altered; it is lengthened, the upper jaw is increased in size, the lower jaw is thickened and lengthened, and the shape of the face is that of an elongated oval, and shows a tendency to become concave. The lips are thickened, the lower one is usually overhanging. The tongue is exposed between the teeth and is more or less enlarged. The nose is large and flat with broadened bridge. The supraorbital ridges project; the eye balls are prominent. There is



usually a low, receding forehead. Often there is marked pigmentation of the skin of the face.

The trunk becomes very large and when viewed from the side, a marked cervico-dorsal curvature is seen, also a slight lumbar lordosis. In front there is a marked projection of the ribs and sternum. There is always alteration in the tone of the voice.

The subjective symptoms are: headache and severe pains in various other parts of the body, excessive appetite, and thirst.

The progress of the symptoms varies with the individual case, the duration being ten to twenty years as a rule. It is one of the most chronic of diseases. The cause of acromegaly is undecided. Depressing mental emotions, rheumatism, gout, syphilis, and hypertrophy of the pituitary body have all been considered as causes.

Case No. 5603 was admitted to the Middletown State Homeopathic Hospital May 19th, 1900, æt. 37; occupation, laborer; nativity, United States. No insane relatives on either paternal or maternal side. Habits of patient and patient's parents correct. Duration of mental disease stated as one year. Diagnosis, melancholia and acromegalia. Assigned cause of mental disease, acromegalia and masturbation.

The patient is suffering from hallucinations of sight and hearing, is greatly depressed mentally and it is claimed that he is homicidal. He is said to have been in the United States Army and stationed at West Point until a short time before admission to the hospital. How long he was in army could not be ascertained; the patient says five years, and that he was discharged because of physical disability, his fingers having grown so large that he was unable to pull the trigger of a gun, as he could not get one of them within the trigger-guard.

On admission he was somewhat demented, though not so demented as he appeared to be. He was confused and did not give a very intelligent account of himself. He has auditory hallucinations and believes that some one is going to execute him by shooting, to punish him for some imaginary crime. When the hallucinations of hearing are active he becomes greatly agitated and frightened, and begs that he be given his liberty in order that he may escape from his imaginary enemies. He said that about three months before he came to the hospital his feet and ankles began to swell and that he became much reduced physically. He complained of pain along the spine, especially between the scapulæ and of some pain in the precordial region. He said he first noticed the change in his face and hands when he was about twenty-five years of age. He was put to bed because of the sluggish mental and the weakened physical condition. At present there does not appear to be the slightest desire to exert himself, nor does he manifest any interest in his surroundings. He lies in bed with head covered and is indifferent to the calls of nature. At times he seems to be apprehensive of some personal danger.

While measurements were being made he resisted and refused to permit them to be completed, saying that he thought he was to be

cut in pieces to correspond with the measurements which were being made.

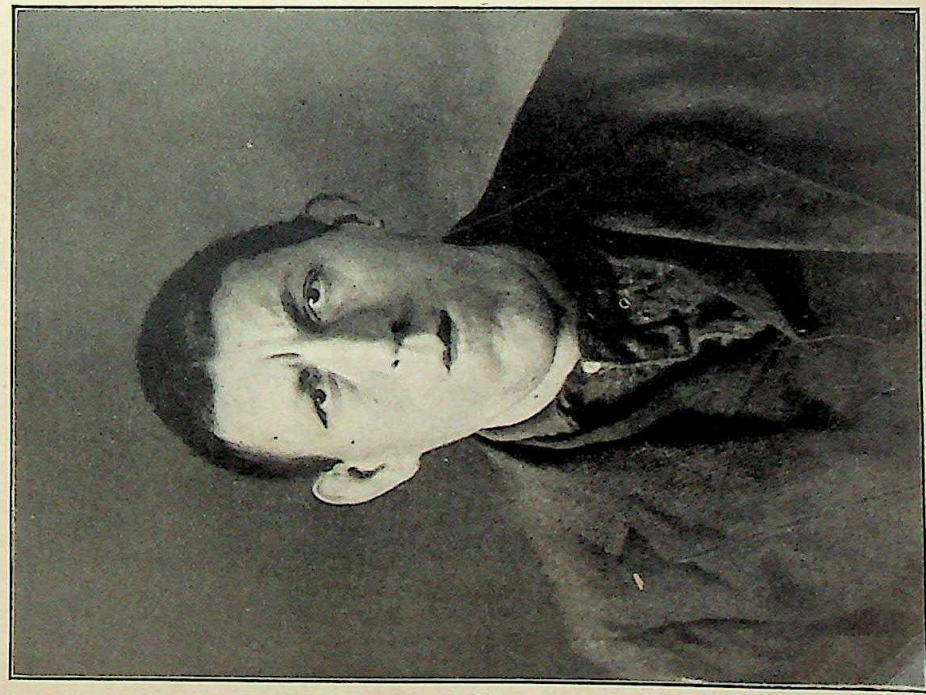
He has suffered from diarrhœa much of the time since admission, though that condition has been relieved for the past six months. He is still confined to his bed because of the feeble physical condition, the mental depression and confusion, and the tendency to be violent and destructive while about the ward. The muscular development is poor and somewhat reduced, though a little better at present than when he first came under observation. His weight when admitted was 218 pounds. He lost in weight after admission thirty-four pounds. The present weight is 245 pounds, which shows a gain of sixty-one pounds from the lowest weight recorded. The tissues are soft and flabby, and his general strength is much below par for an individual of his size.

The great size and the peculiar shape of this man's head and face are apparent at a glance. The ears are enlarged, the cartilages hardened and thickened and the natural form destroyed. His nose is very large and deflected considerably to the right, the nostrils are constricted. The left eye is placed slightly above the level of the right. The lower jaw, however, shows the greatest degree of deformity; it is elongated, the chin protrudes much beyond the normal. The length of the chin is much increased. The hypertrophy of the lower jaw is unequal, it being greater on the left than on the right side. There is almost no growth of hair on the face, only a scattered fringe along the edge of the lower jaw. The tongue is hypertrophied and almost completely fills the mouth. The teeth are much decayed and irregularly placed in the jaws. He has a degenerate, or a V-shaped palate. The voice is thick, muffled, and difficult to understand.

Both optic nerves are atrophied. The disks are grayish white, margins abnormally, sharply defined, and the *lamina cribrosa* distinctly visible, especially upon the right side where the sclerotic ring is seen with unnatural clearness. The retinal arteries are noticeably contracted. Vision is reduced to 15-100 in the right and to 15-30 in the left eye. The visual field could not be determined as the patient refused to obey directions, or to answer questions.

The hands are thick, soft, broad cushions, the fingers are very broad and short. They are flat and spade-like, with considerable bone hypertrophy at the joints. The nails are broad, short and thin, with marked ridges running through them; the nails do not reach the ends of the fingers by an eighth of an inch or more. The feet are large, being twelve inches in length and four and one-half inches in width. They do not show as much deformity as do the hands.

The thorax shows quite as much deformity as does the face and hands. The first three ribs on the right of the sternum have buckled posteriorly, and give the chest wall, in that region, a caved-in appearance. At the junction of the fourth, fifth and sixth ribs, with the ensiform cartilage, on the same side, the buckling is outward, and the chest wall bulges and forms a prominent hump at that point.



This condition gives the right side of the chest a very much deformed appearance. The ribs are broader than normal and the buckling just mentioned is due to the increased length. The right clavicle is freely movable at both extremities, considerable crepitus is apparent on manipulation.

The spine shows much deformity. The back is rounded, and the patient is only comfortable when the head is bent forward. When he stands the chin is held very close to the chest.

The skin is moist and oily. There are a great many small warts on the neck, chest and back.

In other particulars this man, so far as can be discovered, is fairly normal. The bones of the legs and arms do not show any deformity. The heart and lungs are sound. The hearing is normal. He does not void so much urine, nor manifest the great thirst that it is claimed most cases of acromegaly do.

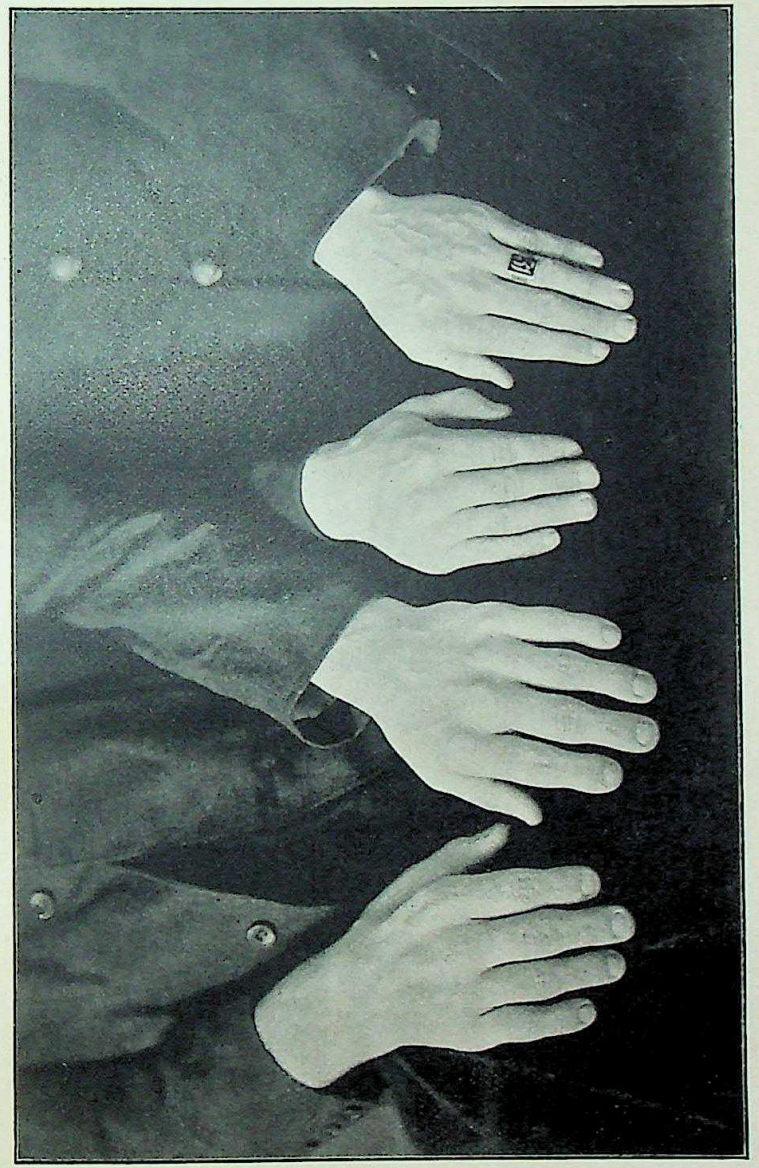
Homœopathic medication has been directed toward the relief of various physical symptoms, as they have appeared from time to time, as well as with the hope of ameliorating the mental apathy and depression. The glandular extracts have not been used in this case.

Herewith are presented a number of measurements which I believe, by comparison with similar ones of a normal man, will demonstrate some of the most important features of this case. Permit me also to call your attention to several photographs which have recently been made, some of which show a well-developed man, in contrast to the subject of this paper.

MEASUREMENTS.

| | Inches. |
|---|---|
| Height | 75¼ |
| Greatest circumference of head | 24½ |
| Naso-bregmatic arc | 5¾ |
| Naso-occipital arc | 15½ |
| Bin-auricular arc | 16 |
| Antero-posterior diameter | 8¼ |
| Diameter between parietal eminences | 5¾ |
| Bin-aural diameter | 6¼ |
| Breadth of head from mastoid to mastoid | 6⅛ |
| Length of forehead from root of hair to root of nose | 2½ |
| Root of hair to tip of chin | 9⅛ |
| Root of nose to tip of chin | 6⅝ |
| Length of nose | 2⅝ |
| Length from nasal septum to tip of chin | 4 |
| Distance from lobule to chin—(right) | 6½ |
| Distance from lobule to chin—(left) | 6½ |
| Distance from tragus to tip of nose—(right) | 6½ |
| Distance from tragus to tip of nose—(left) | 7 |
| Greatest distance between malar bones | 6⅛ |
| Length from temp. maxillary articulation to sym. of lower jaw—(left) | 7⅜ |

| | Inches. |
|---|---|
| Length from temp. maxillary articulation to sym. of lower jaw—(right) | 7⅜ |
| Distance from angle of lower jaw to symphysis—(right) | 4¾ |
| Distance from angle of lower jaw to symphysis—(left) | 5 |
| Length of upper lip in center | 1⅛ |
| Length of chin | 2½ |
| Circumference of neck | 18½ |
| Circumference of chest under arms | 45¾ |
| Circumference of chest at mammary line | 48 |
| Circumference of waist | 47¼ |
| Circumference of body at level of ant. sup. spine of ilia | 44 |
| Antero-post diameter of chest | 11⅞ |
| Lateral diameter of chest | 15⅜ |
| Length of arm from acromion to olecranon—(right and left) | 16½ |
| Circumference of arm around biceps—(right) | 12 |
| Circumference of arm around biceps—(left) | 12 |
| Length of forearms from styloids to olecranons | 12½ |
| Circumference of forearms at middle | 11⅛ |
| Circumference of wrist—(right) | 8¼ |
| Circumference of wrist—(left) | 8⅛ |
| Length of hand from wrist to tip of middle finger—(right) | 7¾ |
| Length of hand from wrist to tip of middle finger—(left) | 8 |
| Length of middle finger from palmar fold to tip—(right) | 3¾ |
| Length of middle finger from palmar fold to tip—(left) | 3⅝ |
| Circumference of middle finger—(right and left) | 3⅜ |
| Circumference of little finger—(right and left) | 2⅝ |
| Circumference of thumb—(right) | 3⅛ |
| Circumference of thumb—(left) | 3¼ |
| Breadth of nail of ring finger—(right and left) | ⅝ |
| Length of nail of ring finger—(right and left) | ⅜ |
| Circumference of hands without thumbs | 10⅝ |
| Length from iliac crest to external malleolus | 41¼ |
| Length from iliac crest to head of fibula—(right) | 26¼ |
| Length from iliac crest to head of fibula—(left) | 26 |
| Circumference of thigh at middle—(right) | 22½ |
| Circumference of thigh at middle—(left) | 22 |
| Circumference of knee—(right) | 17½ |
| Circumference of knee—(left) | 16¾ |
| Greatest circumference of calf—(right) | 15 |
| Greatest circumference of calf—(left) | 15 |
| Greatest circumference of ankle—(right) | 11¾ |
| Greatest circumference of ankle—(left) | 11¾ |
| Greatest length of foot—(right) | 12 |
| Greatest length of foot—(left) | 11¾ |
| Circumference over heel and instep—(right) | 15 |
| Circumference over heel and instep—(left) | 15½ |
| Greatest width of foot—(right and left) | 4½ |
| Width of feet at base of toes | 4 |



## DISCUSSION.

DR. FISKE: I would like to ask the doctor if that is not a good case to experiment with the glandular extract.

DR. ASHLEY: Yes, it would be a good case to experiment with to you gentlemen who are in general practice and prescribe such remedies as you deem best. We, as physicians in the Middletown State Homœopathic Hospital, are denied that privilege. The glandular extract has not been proven homœopathically, I believe. The institution with which I am connected was established as a homœopathic hospital, and we have as yet to prescribe in any other way than according to the totality of symptoms and the laws of Hahnemann. Hence, we are denied the privilege of making some of these experiments.

DR. FISKE: The reason I spoke of it, Mr. Chairman, so many good homœopaths here are using the antitoxin, which is on the same plane in its relation to homœopathy.

DR. ASHLEY: Yes, I have noted yesterday and to-day how far we have deviated from the laws of homœopathy, or the homœopathic physician, as defined in our annual transactions.

DR. MCDOWELL: *Mr. Chairman*, I would like to ask the doctor whether any examination of this man's eyes has been made. I notice in examining the photograph that the right eye is considerably higher than the left. Now, according to the statements of a number of competent observers a difference in level, and variations in the horizontal plane, of the eyes, have produced a remarkable series of deviations from the normal in health, varying from renal disease to epilepsy, insanity and almost anything you please; and I wondered whether any observations had been made as to the condition of this man's eyes.

DR. ASHLEY: You mean the situation of the eyes, or the condition?

DR. MCDOWELL: The location.

DR. ASHLEY: Yes, there is a slight difference in the elevation, or the horizontal line, of the eyes, the right eye being a little the higher, but I have found that so much that I did not make a note of it. In fact, there are a great many minor things in connection with this case that I did not make a note of, as I did not wish to increase the length of the paper. There is almost nothing in the external appearance of this man that is normal.

DR. MCDOWELL: I was led to make this remark by a paper that was written by Dr. Linnell, in relation to a man who was confined in the Westboro Asylum at different times for recurring attacks of insanity. These were finally cured permanently, at the beginning of one of his attacks, by correcting his astigmatism together with the difference of level which was found to exist. I wondered whether anything in this direction was being done or recommended in the Middletown Asylum.

DR. BUTLER: I would like to ask Dr. Ashley what ever became of that case that was reported here several years ago by Dr. Clara

Barrus, on which there was a good deal of discussion as to whether it was acromegaly or not, There were several radiographs, and the case was referred to by our old-school friends.

DR. ASHLEY: The case is still confined in the hospital and remains stationary and in just such condition as it was at the time Dr. Barrus reported it some years ago.

DR. BUTLER: Have you decided what it is?

DR. ASHLEY: Nothing further. The doctor who reported the case is still of the opinion that it was acromegaly.

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# REPORT

OF THE

BUREAU OF GYNÆCOLOGY.

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"The Physical Signs and Treatment of Gonorrhœa in Women," L. L. DANFORTH

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## THE PHYSICAL SIGNS AND TREATMENT OF GONORRHŒA IN WOMEN.

L. L. DANFORTH, M. D.,
NEW YORK CITY.

I am led to present for your consideration on this occasion, a subject which, to my mind, is of paramount importance to all who practice gynæcology, on account of the irreparable damage the disease under consideration does to the pelvic organs of women. I refer to gonorrhœa. One of the most distressing features of this malady is that it is often met with in innocent women, who, though permanent sufferers, never suspect the nature of the disease or its source. It is no uncommon occurrence for me to receive in my consulting room a young couple, perhaps a bride and groom of only a few weeks. The husband privately introduces the object of his visit by stating that the young wife has recently developed considerable pain on urinating and that there is a slight vaginal discharge, both new and distressing symptoms which had never been complained of before. A vaginal examination reveals suspicious signs to the experienced observer, and the microscope, supplemented by the confessions of



the husband, who states that he had suffered from an attack of gonorrhœa, of which he was pronounced cured before marriage—confirms the diagnosis. The young wife has a subacute gonorrhœa. So important in its effect upon the future health of the woman is this prevalent malady, that I propose to call your attention to some of the physical signs by which it may be recognized because its early diagnosis, and prompt and persistent treatment is essential to a cure. And, I may add, that in my opinion there is no disease, at least of such common occurrence, that is so often overlooked, so much neglected and so improperly and unsatisfactorily treated as this, by the vast majority of physicians, notwithstanding all that has been written about it in the last few years. I shall take little of your time to describe acute gonorrhœa for we see few such cases. The physical signs are so characteristic a diagnosis is easily made.

The urethral meatus, vestibule, nymphæ and ducts of the vulvo-vaginal glands will be observed to be in a high state of inflammation. The act of urination is painful, the parts are sensitive to touch and bathed in pus. The orifices of the ducts of the vestibule stand out prominently on the surface of the mucous membrane and there is an area of redness around them. The vulvo-vaginal glands and their ducts are tender to the touch. The mucous membrane of the vagina is swollen and the follicles which in a healthy state can hardly be seen, can now be easily traced as small, angry red spots—not larger than the head of a pin. The parts may be covered with a thin muco-purulent secretion. On further inspection, the cervix will be found to be involved, the glands of Naboth are swollen, an area of redness extends for a considerable distance about the os uteri and an abundant secretion of pus bathes the parts.

I have recently had a very severe case of acute gonorrhœa in a woman who was contaminated by an unfaithful husband. Fortunately, the wife suspected the cause of the husband's trouble, and quickly appreciating the nature of her own, promptly placed herself under treatment. The symptoms were very acute, and comprised all those I have mentioned, but she had, in addition, a very severe gonorrhœal inflammation of the rectum. This is a most distressing complication and one which oftener occurs than is generally supposed. But it may cause no symptoms and hence is not observed. Baer states that statistically the presence of rectal gonorrhœa is 38.2 of women (429 cases) who had gonorrhœa. In this case, the pain in the rectum and down the thighs was intense; it was due to spasm of the sphincter ani.

Another case of acute gonorrhœa, one of the worst I have ever seen, occurred in a young woman three months pregnant. The disease was contracted at the time of the fruitful coitus, and having been neglected assumed a very severe form, terminating in a miscarriage. Acute gonorrhœa and pregnancy when met with as associated conditions give rise to the most acute symptoms. The augmented pelvic congestion incident to pregnancy greatly aggravates the intensity of the disease.

If acute gonorrhœa in women is treated promptly and with effective

remedies, I think it is susceptible of a perfect cure; but if neglected and allowed to drift into the chronic stage it becomes exceedingly difficult to eradicate. The subacute insidious cases, the so-called latent gonorrhœa, presents well-defined lesions. I have yet to see the woman who has suffered from chronic or latent gonorrhœa, whose vulva presents a normal appearance on inspection. The orifices of the glands of the vestibule remain indefinitely and in many cases for years, as red and angry spots to mark the former dwelling-place of the gonococcus. The ducts of the vulvo-vaginal glands show the most positive evidence of the work of the gonococcus. Around their orifices may be seen a red, sensitive area and from the ducts may often be pressed a small quantity of thin, muco-purulent fluid. The mucous membrane of the urethra and Skene's glands with their ducts is permanently changed in character; the meatus urinarius is reddened so much as to make the parts resemble an ordinary urethral caruncle. A small amount of thin, purulent fluid may often be squeezed from the urethra. The glands of the cervix uteri become affected and give rise to a discharge which is not different from that of an ordinary leucorrhœa due to passive congestion of the pelvic structure from general or local causes. An area of redness around the os uteri is a significant sign. But the cervical indications are practically negative unless taken into consideration with other signs, or the microscope is employed to aid in determining the diagnosis. It seems quite certain that the glands of the cervix are a favorite situation for the gonococci, for when they have once invaded these structures, they appear to linger there as long or longer than they do about the deeper parts of the male urethra. As Sinclair says: "Developing in a new soil, they are endowed with a greater vitality than the starved stock from which they sprang."

If the gonococci stopped at the cervix uteri, it would indeed be fortunate. But such is not the case. The most damaging effects of this organism is displayed in its ravages upon the deeper structures of the sexual organs of women. Dysmenorrhœa, sterility, menorrhagia, and pathological changes in the Fallopian tubes and the ovaries are all possible and indeed probable results of the influence of gonococci upon these structures. An infective process which is capable of producing such a variety of pathological lesions as I have hinted at is certainly a most serious matter for the patient and demands the most skillful treatment applied at the earliest possible moment. To do this, requires an early diagnosis. If it be possible to obtain from the patient a history of an acute attack, we shall be greatly aided in our investigations. But, unfortunately, this cannot be accomplished in many cases for domestic reasons. The symptoms may be so striking and the circumstances preceding and accompanying the initial symptoms so suspicious as to lead the most unsuspecting woman to divine the cause. If the case is one of the so-called latent variety there may have been no symptoms sufficiently acute to be remembered. In this instance where the woman can give no hint as to the nature of the malady, we should interrogate the husband, and if possible obtain the clue we seek from him. In any case, the microscope may prove a great aid in clearing up the diagnosis. When the gonococcus has been surely seen, there can be no further doubt. But even when the clinical signs are sufficiently plain to enable the experienced observer to be morally sure of his diagnosis, we do not always find the gonococcus even after repeated trials. Their effects are apparent but the micro-organisms themselves are hard to find. If we get a confession and no gonococci, we may be sure of our ground. If we find gonococci, and we meet with a denial of guilt we may be equally sure.



### TREATMENT.

In acute gonorrhœa the treatment should be applied daily by the physician himself until the acute symptoms have subsided. The vulva, vagina and cervix uteri should first be thoroughly cleansed with a solution of green soap and hot water. The urethra should be irrigated with a boracic acid solution. Every fold of mucous membrane of vagina, the rugæ and, so far as possible, the glands in the cervix should receive a thorough cleansing. The most effective local anti-gonorrhœal remedies are ichthyol and the silver preparations.

Ichthyol has an exceedingly beneficial action, especially in cases of acute gonorrhœa in women. Cases of acute vaginitis and vulvitis easily yield to a few applications of wool tampons saturated in a preparation of ichthyol and glycerin, equal parts. This should be kept up daily until the discharge ceases and then it may be used occasionally, say three times a week. A solution of protargol (two to five per cent. strength) acts very promptly and is less objectionable in one respect—it has no unpleasant odor like ichthyol. Tampons may be saturated with protargol (two per cent.) and left in the vagina twenty-four hours with certain results. The inflammation subsides rapidly.

For acute gonorrhœa of the rectum, irrigations with hot salt water, or hot boracic acid solution (℥i to ℔i) through Carleton's return flow rectal irrigator will be found very soothing and a necessary preliminary to the application of medicines. The pain and spasm of the sphincter ani render the use of any local application very painful. In the case of rectal gonorrhœa I have referred to, it was impossible to insert even the smallest nozzle of the syringe without excruciating pain, and I had to place the patient under ether, and stretch the sphincter. But even that was not sufficient to relax spasm, and I was obliged to make a partial submucous section of the muscle before it would yield permanently. This was followed by daily irrigations of a hot solution of Merrill's watery extract of hydrastis (℥j to ℔ii) and three times a week I injected about two drachms of a two per cent. protargol solution and allowed it to remain in the rectum. The cure of gonorrhœa of the rectum when spasm of sphincter is not present is easy by means of these remedies.

Acute gonorrhœa of the endometrium is not an invariable nor an early sequence of the disease in the vulva, vagina or cervix. But it may ensue at any time from exposure, over-indulgence in coitus or the passage of a sound, and it is especially liable to occur during

menstruation. The symptoms are acute: tenderness of all the pelvic organs and elevation of temperature to 101° or 102°; uterine pains; discharge of pus from the uterus with marked congestion of the organ on inspection. The discharge of pus is often profuse and tinged with blood. The attack may last one or two weeks, but the purulent discharge will often last much longer. Pryor says that "A woman previously well, suddenly attacked with acute endometritis a few days after connection probably has gonorrhœa. By far the greater number of such cases of acute endometritis which do not occur after abortion or labor are due to gonorrhœa."

The advisability of curetting a uterus afflicted with acute gonorrhœal endometritis is a subject upon which there is considerable difference of opinion. It is contended by some that interference with the interior of the uterus is almost certain to result in complications such as the extension to tubes, ovaries and peritoneum. But this unfortunate sequence is almost sure to follow if active treatment is not adopted; on the other hand, the tendency to complications is not increased if curettage is properly done and there is the possibility that a radical cure may be effected. I do not believe that gonorrhœa of the endomentrium can be cured except by surgical means. But curettage does not always prove curative and then we have to deal with the chronic form of the disease. In such cases there is always a purulent discharge and the cervix is the seat of glandular disease of the most obstinate variety. It is with this form of the disease that complications of the tubes, ovaries and peritoneum are usually seen. It is because of the tendency of this disease to affect the deeper structures of the pelvis that the initial symptoms demand such vigorous treatment. The most positive sign of disease in the peri-uterine tissues is persistent pelvic pain.

The most constant sign of chronic gonorrhœal endometritis is a persistent purulent discharge. But it is sometimes difficult to determine whether the cervix alone is involved, or both the cervix and endometrium. Cleansing the cervix carefully does not settle the diagnosis. A mixed purulent and mucous discharge may come from the uterus and it is difficult to tell exactly its origin. I have been greatly puzzled by such cases. Treatment of the cervix should be faithfully tried first, before the uterus is curetted. I have found the use of chromic acid i to the ounce of water, one of the very best applications for this purpose. The parts must be first thoroughly cleansed and dried and then the chromic acid applied on an applicator. This may be repeated twice a week for a few times, then once a week. If the cervix remains inflamed under persistent treatment, or if the purulent discharge continues after the cervix is brought to a normal condition, then we may conclude that the endometrium is involved. Some cases of chronic cervical endometritis will not yield to the chromic acid treatment. In the more obstinate forms of the disease, I have used with satisfaction, applications of fuming nitric acid. (See Thomas and Munde's Works on Diseases of Women, page 291.) Local applications to the corporeal endometrium do no good in chronic gonorrhœa, indeed they are worse than useless.



A curettage may be done, and it will generally prove effective in checking the discharge for the time being, at least, and in limiting the source of further infection. But as the adnexa are more or less affected in the majority of instances of chronic gonorrhœal endometritis something else is required besides curettage. A radical operation upon the affected tubes and ovaries will sooner or later be a necessity. Whether the operation shall be done by the vaginal route or by opening the abdomen is a question which will have to be settled by the predilections of individual operators, and the conditions inherent in each individual case.

A posterior colpotomy is certainly a conservative procedure, and will relieve many cases. But for old pus tubes and adherent and diseased ovaries the most thorough operation is the best and that is by celiotomy. It is beyond the limits of this paper to deal with this phase of chronic disease of the adnexa by operative means. My aim is to so present the subject that gonorrhœa in women may be more quickly detected and its earlier manifestations promptly cured.

A few words more with reference to some of the external manifestations of the disease. We are apt to forget that gonorrhœal infection can produce stricture and disease of the female urethra just as readily as it does in that of the male. Many, indeed most of the affections of the urethra in women may be explained by a knowledge of this fact, and treatment will be effected in proportion as this is recognized.

Abscess of the vulvo-vaginal gland, or chronic disease in this gland or its duct, can only be treated successfully by extirpation of the gland, rather than simple evacuation of its contents.*

Before closing I would say a word as to the existence of gonorrhœa in young children. That such a loathsome disease can be found in young children as a direct result of contact of the sexual organs seems incredible. But it is not impossible. This very day I was asked by the house physician at the Hahnemann Hospital to see a little girl not over six years old who had just been admitted to the ward with what was said to be a "bladder trouble." I requested the nurse to prepare the little patient so that I could see the genital organs, and I found the vulva and thighs bathed with pus. An examination was made of a drop of pus with the microscope and gonococci found unmistakably. How the child got the disease or when, I do not know, but she had gonorrhœa without doubt. The chief symptom was the urinary distress. We should not forget the possibility of infection in children. Profuse purulent leucorrhœa, associated with acute bladder symptoms should put the physician on

*The local manifestations of chronic gonorrhœa in women are not the only evidences of disease to be observed, if the physician is mindful of the general welfare of his patients. Women with chronic gonorrhœa are sick women! There is no single symptom or single organ which seems afflicted; the patient is in general bad health; dyspepsia, anæmia, loss of flesh, constipation, skin affections; these are some of the disorders which develop as the result of what would seem to be a general systemic poisoning in addition to the more apparent local effects of the gonococcus. To cure our patients we must take cognizance of the general health, and select the remedy appropriate to the whole condition; in other words, prescribe the proper homœopathic remedy, whatever it may be, at the same time that we pay attention to hygiene and diet.

his guard. I have seen a number of such cases. Gonorrhœa is a much more common malady than the general practitioner is wont to think, and its early recognition and treatment is of the greatest importance to the welfare of the affected patient. (Applause.)

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## DISCUSSION.

DR. BUTLER: *Mr. Chairman,* I rise to ask Dr. Danforth if there is no homœopathic treatment for this. Now, how would a high potency man like our friend Dr. Terry do if he didn't use any local treatment? Would there be no probability of any cure? and is it useless for the homœopathic physician to try to treat that homœopathically?

DR. TERRY: *Mr. Chairman,* I would like to speak on that. I quite agree with Dr. Danforth that these conditions require local measures. I perhaps am less radical than most surgeons in regard to the treatment of this difficulty after it has extended up into the uterus and fallopian tubes. In other words, I believe in trying the less heroic measures first. So far as a douche is concerned, I prefer such remedies as sulphate of zinc, the old, tried remedies of the allopathic school; and sulphate of zinc, and those remedies, as a douche, if the patient is put in proper position, will cleanse, purify and disinfect the vagina. When the difficulty has extended into the uterus, I would not pack the uterus. I would dilate the cervix, wash the uterus with a preparation of bromin and soda. I usually employ a drachm of the preparation which has been published in the American Journal of Homœopathy—one drachm to ℥ii water is sufficient, with bicarbonate of soda, to make the preparation slippery. After the uterus has been douched, I drain the uterus always with a tampon of iodoform gauze, and usually the patient will get along slowly. Gentlemen, it is a matter of weeks, and the treatment must be made by yourself, at your hospital or at home. Where cases come to you in this chronic form, having passed through the acute stage, it has often taken me from twelve to fourteen weeks to cure them by this method, and then I have been obliged to break up adhesions with my finger, into an opened Douglas's cul de sac unless irreparably diseased, but, however, that is better than removing the ovaries. If I did not obtain my results in that way, of course, I should do the ordinary operation. I do not recall that the doctor mentioned about the gonococci extending up into the urethra.

DR. DANFORTH: I did.

DR. TERRY: I beg your pardon; I did not hear you. I usually use in a case of that sort one or ten sandal-wood capsules about two or three times a day, with the bicarbonate of soda to neutralize the urine. In all the treatment that has been instituted in the last few years, I have never seen anything equal to the above in man or woman, to neutralize and ease the flow of the urine, hastening the cure.

DR. TUTTLE: *Mr. Chairman,* I think we cannot emphasize too much the importance of the early recognition of gonorrhœa in women. Perhaps one reason why we do not recognize it is because it so frequently occurs without any symptoms in the urethra. The author of the paper, in relating the symptoms, and in what he said later in the paper, did not, I am sure, mean to imply that symptoms in the urethra were necessary. In fact, I think statistics show us that quite a large percentage of cases, if I remember correctly, something like twenty-five to thirty-three per cent., have no symptoms in the urethra. It is particularly in the latent form of gonorrhœa, when the patient comes in with a history of a discharge, and we take the history of the case, and fail to find the urethral symptoms, that we are misled, and we do not continue the investigation with the microscope as carefully as we should if we found a urethral history. In regard to the treatment, I firmly believe that gonorrhœa starts as a local disease. That it is due to micrococci, there is no doubt. And I believe it is only rational to attack it locally as well as symptomatically. A treatment that has given me very good satisfaction, and I may say the best satisfaction, is the use of protargol. I tried it first, as the author has mentioned, upon tampons, but realizing the necessity of opening up the folds of the vagina and keeping the solution in contact with the entire mucous membrane, I decided to saturate the gauze with a rather weak solution, because where the vaginal mucous membrane is kept constantly in contact with a protargol solution, or any other, you cannot use the strength that you could if it were only used as an injection, or upon a tampon. Therefore, I have been in the habit of using a one or two per cent. solution of protargol, saturating sterile gauze with it, and packing very lightly, but very completely, the whole vagina, changing this twice a day, preceding the packing with a thorough cleansing either with soap and water, or peroxide, or some antiseptic solution. This must be done by a physician or by a very competent nurse. When the disease extends up into the uterus, I have signally failed in removing it from the uterine cavity or arresting its progress by curetting, and I am yet to be convinced that curetting does very much good, more than to stop temporarily the discharge, and I am sure that in one of my cases, at least, it seemed to increase and accentuate the advancement of the disease into the tubes.



DR. DANFORTH: I will take just a moment, Mr. Chairman, to reiterate what I have said in my paper, viz., I do not believe we can wholly cure gonorrhœa in women by internal medication. It is a local disease at first, and we must destroy its cause, the gonococci. We have medicines which will do this. Protargol, I believe, is one of the best for this purpose. Ichthyol is also an excellent remedy, but protargol is to be preferred. When the disease has invaded the uterus, my experience is that curettage does only temporary good, and sometimes fails entirely. We must not forget, furthermore, that women with gonorrhœa, whether the disease be acute or chronic, are sick women and must be treated with internal remedies as well as local remedies if we would cure the disease completely. This is where the homœopathic remedies apply with such excellent effect.

# PROCEEDINGS

OF THE

## Thirty-Sixth Semi-Annual Meeting of the Homœopathic Medical Society of the State of New York, held in Utica, Sept. 16th and 17th, 1902.

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The meeting was called to order at 10:25 o'clock Tuesday morning, September 16th, by the President, JOHN L. MOFFAT, who introduced the REV. HENRY H. TWEEDY, of Plymouth Church, Utica, who invoked the divine blessing.

PRESIDENT MOFFAT then introduced His Honor, CHARLES A. TALCOTT, Mayor of Utica, who addressed the Society in a few words befitting the occasion. PRESIDENT MOFFAT thanked the Mayor for his cordial welcome to the City of Watson, Terry and Haines.

SECRETARY DEWITT G. WILCOX read the minutes of the fiftieth annual meeting, which were approved.

PRESIDENT MOFFAT appointed the following committee:

*Committee on Attendance.*—H. D. Schenck, S. W. Hurd, Walter Sands Mills and Fred D. Lewis.

DR. MOFFAT called attention to two innovations, one relating to the new method of electing officers, and the other relative to the practice of having badges prepared with the name and address of each member and visitor appearing legibly upon the same.

### PRESIDENT'S ADDRESS.

BY JOHN L. MOFFAT.

*Ladies and Gentlemen:*

"Will you walk into my parlor?"
Said the spider to the fly,
"'Tis the prettiest little parlor
That ever you did spy,"

beautifully furnished for the feast of reason and flow of soul to which some of our old-school brothers are wooing us. If we should be satisfied with their plausible reasoning and content to have the flow of soul only in one direction, the digestion of the lion would soon make hash of our mutton.

*To-day homœopathy is facing the gravest crisis in its history!*

The lion is roaring us "gently as any sucking dove, he will roar you an 't were any nightingale" and assure us, "If you think I come hither as a lion it were pity of my life; no, I am no such thing, I am a man as other men are."

The president of the old-school society of this state is officially inviting all legal homœopaths and eclectics to join the allopathic state and county societies, without expecting us to surrender or change any particular belief as to therapeutics or our relations with existing medical societies.

"The voice of the turtle is heard in the land!"

Methinks I hear some one cry "Victory! Homœopathy is formally acknowledged by the dominant school as a therapeutic system! Let us show ourselves equally broadminded, and on the floor of their societies demonstrate the advantages of similia!" Not so; that is a mistake! We are recognized as a powerful political organization, but our therapeutics are not recognized, and homœopathy cannot yet flourish, or even survive in their societies.

Dr. Hopkins, representing the increasing liberal element of the allopathic school, is sincere in his desire for medical unity—a political possibility quite distinct from medical uniformity which he acknowledges to be impossible. Like President Reed, of the American Medical Association, and Dr. Osler, of Johns Hopkins' University, he cares nothing for homœopathy! They acknowledge our political power and, recognizing that the old policy of persecution was a mistake, hope to accomplish by the warmth of their embrace what the rudest blasts of boreas failed to do.

Twenty-one years ago the American Medical Association ostracized the New York State Society, old-school, for its liberal attitude toward the code of ethics. For the past year or two there has been a strong effort to right that wrong and unify the state society and association, thus healing the division in the allopathic ranks of this state; conquering homœopathy is quite a secondary question with them.

In its May issue the *Buffalo Medical Journal*, which is advanced liberal—expressed the conviction that the code of ethics is dead and buried; but the New York State Association has proposed in a revised code to the American Medical Association, Art. IV, § 2: "The good of the patient being the sole object in view, any physician having a license to practice medicine conferred by the state may be aided in consultation." But immediately adds, § 3: "No physician who indicates to the public that his practice is based on a sectarian system of medicine shall be entitled to professional fellowship or to recognition in medical bodies."

Manifestly we should hesitate at least until Dr. Hopkins and the liberal party are firmly in the saddle; they are probably still but a small minority of the dominant school.

The time has not yet come for us to accept this invitation. Wait patiently and firmly, there is no hurry, it will come; but do not forget that our weak brothers in other states and countries will be injured if we join the allopathic societies.



With President Wood, of the American Institute of Homœopathy, I acknowledge that the unity of the medical profession is desirable under proper conditions; that is to say, homœopathy must first be fairly and thoroughly taught in all old-school colleges. When that is done—and not until then—we may join the dominant societies while many, if not most, of us will continue active in our homœopathic societies as specialists in this line of therapeutics, just as men interested in electric therapeutics have their electrical societies. But I strongly disagree with Dr. Wood and deprecate his statement that he sees no objection to our joining allopathic societies provided we are not called upon to renounce our name or principles. That has now been conceded to us, and we will yet win all we ask if we do not lose our head in what erroneously appears to be the moment of victory.

Our greatest danger is from such opinions in our own ranks, especially when promulgated by men who have been our leaders. Save us from our friends! In their haste to be equally magnanimous and broadminded in a movement to bring about medical uniformity, those of us who join old-school societies imperil our political power, playing directly into the hands of our friends, the enemy, whose object, according to Dr. Hopkins, is "medical unity, a legal state for political purposes".

I earnestly repeat, the times are not yet ripe! The allopathic bourbons are still in evidence, still in power. The millenium is not yet here; the lion is still a carniverous animal, and the lamb prefers the outside berth.

If one of us accept Dr. Hopkins' invitation why should not another join the allopathic societies? And another? And another? And another?

Then what effective reply could be made, by our legislative committee, for instance, to a governor anxious to abolish our separate board of examiners or to cripple Middletown or Gowanda on the plea that we being members of the united medical profession homœopathy can no longer have a distinct claim upon the state?

Each one of us, in his or her sphere, no matter how humble it be, is the representative of homœopathy, the custodian of its honor; according to his personality will the world about him regard our school with increasing or with diminishing respect.

Of the medical profession it has been wittily said that "doctors, like verbs, may be classified as regular, irregular and defective". We want no defections from our ranks, no Laodiceans!

Every unit counts—it is only by virtue of their numbers that the allopathic is the dominant school; it is our numbers and our organization (founded upon a living belief in similia) that make us strong in the community and respected by the old-school politicians.

Let no sentimentality, no misapprehension of the situation, no trust in Delilah, undo the work of the last fifty or more years in this state!

## REPORT OF NECROLOGIST.

W. S. GARNSEY, Necrologist, made the following remarks before presenting his report:

*Mr. President and Members of the Society*: I wish before making any report to thank the members of the Society for the assistance they have rendered me in furnishing these reports. You all appreciate that it is impossible for me personally to know all of these doctors, and when I request assistance it is almost always kindly given and I fully appreciate it. I hope our Secretary in the Annual Volume will always give credit to the persons who wrote the articles.

I would say regarding our much lamented Prof. William Tod Helmuth, M. D., LL. D., that I felt we could not give him too much notice, occupying the position which he did in this Society and in the homœopathic profession of the United States for the past nearly half century. At my request Dr. W. H. Bishop prepared a historical sketch of Dr. Helmuth, which is quite complete and well worthy of publication, but as it is quite lengthy it might be well possibly to omit reading it at this time. Dr. Eugene H. Porter promised me to deliver a eulogy on Dr. Helmuth at this time, but he is not here. I caught him by telephone just before coming to this room and he wished me to say that it was impossible for him to be here, that he was going to New York on important business this afternoon and that he absolutely could not come and he wished me to express to the Society his regrets. We are sorry, but his eulogy of Dr. Helmuth will appear later. I wish, however, to read a set of resolutions that were sent to our President, from the Homœopathic Society of Illinois, and which he forwarded to me:

CHICAGO, May 17th, 1902.

*Dr. J. L. Moffat, President Homœopathic Medical Society of the State of New York, 17 Schermerhorn St., Brooklyn, N. Y.:*

DEAR DOCTOR—At the Forty-seventh Annual Meeting of the Illinois Homœopathic Medical Association, on the news of the death of Dr. Wm. Tod Helmuth, the following resolutions were adopted:

WHEREAS, The hand of death has taken from among us our dearly loved homœopathic brother and our warm hearted and talented friend, Dr. Wm. Tod Helmuth, of New York City; therefore, be it

*Resolved*, By the Illinois Homœopathic Medical Association: That in the taking away of Dr. Wm. Tod Helmuth we are painfully aware that the entire homœopathic profession has sustained an irreparable loss. He was a great doctor, a great author, a great surgeon, a great teacher, a great leader, a great orator, a great poet, a great homœopath, a great man. The many ideals he has furnished us all, in all these characteristics and accomplishments, are our inheritance and our consolation. These can never die and for that we are truly grateful. We all listened to him, we all learned from him, we all respected him, we all loved him, we shall all miss him, we shall all remember him.

*Resolved*, That we extend to his family, his college, his city, his state and his school of medicine our heartfelt sympathy, and that we feel that steps should be immediately taken to do all that lies in our power to commemorate his memory, that the rich legacy of ideals he has passed down to us may be crystalized into substantial material shape for the benefit of those who must follow on after we too have closed our earthly careers.

*Resolved*, That a copy of these resolutions be sent to the bereaved family, the faculty of the New York Homœopathic Medical College, the New York State Homœopathic Society, the American Institute of Homœopathy, and to be preserved with the archives of this Society.

E. H. PRATT,
WILSON A. SMITH,
T. C. DUNCAN,
*Committee.*

EDGAR J. GEORGE,
*Secretary.*



When I heard of the death of Prof. Helmuth, May 14th last, I felt that I had met a great personal loss and that each member of our Society who knew him would feel the same I wanted some one to deliver a eulogy on him at this time. I very quickly decided that no one could do it better than Dr. Selden H. Talcott. Accordingly I wrote him, and received a letter from his wife in reply, saying that Doctor Talcott wished her to state that he thanked me for the honor, and that it would be a pleasure for him to comply with my request if his health should permit, but at present he was confined to his bed with an acute attack of dysentery.

Little did I think then that by June 15th this other great soul would have passed on. Thinking that no one knew Dr. Talcott better than his first assistant, so long associated with him in hospital work, I invited Dr. Ashley to contribute his memoir, which he consented to do. Dr. Ashley is with us, and I asked him to read this article, but he asked to be excused, saying that owing to his intimate relations with Dr. Talcott for so many years, having lived in his family and known him as but few could know him, he felt that he could not trust his voice and feelings to read this article. (See Appendix.)

Dr. Garnsey reported the following deaths: George H. Church, Henry M. Smith, George H. Doty, William Tod Helmuth, Selden H. Talcott and Clarence W. Cornell. (See Appendix.)

## REPORT OF BOARD OF CENSORS.

The following thirty-eight applicants were elected to permanent membership:

| | ENDORSERS. |
|---|---|
| ALLIAUME, CHARLES E., Utica, *XI, '95, | H. C. Allen, E. B. Nash, C. T. Haines. |
| ANGEL, MILTON H., Salt Point, I, '82, | J. I. Dowling, Bukk G. Carleton. |
| AUSTIN, A. EUGENE, New York, I, '97, | Walter S. Mills, S. W. Hurd. |
| BARKER, G. E., Spafford, VIII, '76, | Gordon W. Hoyt, J. W. Sheldon. |

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| BIRDSALL, EDGAR, Brooklyn, I, '99, . . . | Herbert D. Schenck, Orando S. Ritch. |
| BREWSTER, GEORGE FRANKLIN, Middletown, I, '90, . . . . . | Robert Woodman, M. C. Ashley. |
| CARPENTER, ARCHIBALD DIXON, Buffalo, III, 1902, . . . . . | J. G. Chadwick, George T. Moseley. |
| CONKLIN, R. G., Batavia, I, '96, . . . . | J. G. Chadwick, Shirley R. Snow. |
| DICKIE, PERRY, Brooklyn, I, '80, . . . . | Edward Chapin, John L. Moffat. |
| DIEFFENBACH, WILLIAM H., NewYork, I, 1900, | Bukk G. Carleton, Walter G. Crump. |
| DURRIN, M. C., Brooklyn, I, '99, . . . . | Herbert D. Schenck, Orando S. Ritch. |
| EVERETT, EDWARD ALFRED, Middletown, I, '97, . . . . . | J. I. Dowling, R. C. Woodman. |
| FREEMAN, WM. HAZEN, Brooklyn, V, 1900, . | John L. Moffat, Herbert D. Schenck. |
| GENNERICH, CHARLES, New York, I, '96, . | B. G. Carleton, W. G. Crump. |
| GREEN, ARBA R., Troy, I, '80, . . . . | J. I. Dowling, D. G. Wilcox. |
| HALL, C. B., Copehangen, I, '94, . . . . | E. A. Simonds, W. H. Nickelson. |
| HARRIS, J. W., New York, I, '82, . . . . | B. G. Carleton, W. G. Crump. |
| HORTON, CLAUDE A., Glens Falls, I, '92, . | J. I. Dowling, B. G. Carlton. |
| IVES, NATHANIEL HOLMES, Mt. Vernon, I, '95, | J. I. Dowling, Walter S. Mills. |
| JOHNSON, HOWARD P., Cortland, III, '81, . | Gordon W. Hoyt, E. B. Nash. |
| LITTLE, WILLIAM, Sherburne, I, '94, . . . | E. E. Snyder, A. P. Powelson. |
| MACKENZIE, JOHN A., Lima, I, '84. . . . | C. F. Otis, Herbert D. Schenck. |
| NASH, E. B., Cortland, VIII, '74, . . . . | J. L. Moffat B. B'L Baylies. |
| POWEL, MILTON, New York, III, '90, . . | W. S. Mills, W. G. Crump. |
| RANDALL, EDWARD G., Waterville, III, '98, . | A. R. Grant, C. G. Capron. |
| RANKIN, EGBERT GUERNSEY, New York, VII, '79, . . . . . | Wm. Francis Honan, E. D. Klots. |
| ROBBINS, A. JEROME, Mayville, XII, '91, . . | J. G. Chadwick, D. G. Wilcox. |
| ROPER, FREDERICK EUGENE, Norwich, VIII, '88, . . . . . | E. E. Snyder, C. T. Haines. |
| SEWARD, JOHN PERRY, New York, I, '93, . | Wm. H. Van den Burg, E. D. Simpson. |
| SMITH, GEORGE H., Brooklyn, I, '69, . . | H. D. Schenck, Orando S. Ritch. |
| SMITH, GEORGE H., JR., Brooklyn, X, '98, . | H. D. Schenck, Orando S. Ritch. |
| THORPE, JARVIS L., Clyde, III, '99, . . . | W. L. Hartman, D. G. Wilcox. |
| TRAVERS, OSMOND J., Saratoga Sp'gs, VIII, '77, | J. I. Dowling, John A. Pearsall. |
| VAN SCHOONHOVEN, C. S., Brooklyn, I, '78, | H. D. Schenck, Orando S. Ritch. |
| VON BONNEWITZ, ORLANDO R., New York, IV, 97, . . . . . | W. S. Mills, W. G. Crump. |
| WEMMEL, A. ANDREW, Brooklyn, IX, '75, . | H. O. Rockefeller, Orando S. Ritch. |
| WILLCOX, GEORGE W., Hamilton, I, '95, . | J. I. Dowling, W. G. Crump. |
| ZECKHAUSEN, HARRY, New York, I, '96, . | W. S. Mills, W. G. Crump. |

* I. New York Homeopathic Medical College and Hospital.
II. New York Medical College and Hospital for Women.
III. Hahnemann of Philadelphia.
IV. Hahnemann of Chicago.
V. Chicago Homeopathic Medical College.
VI. College of Physicians and Surgeons, New York.
VII. University of the City of New York, Medical Department.
VIII. Cleveland Homeopathic Medical College.
IX. Eclectic Medical College, New York.
X. Long Island College and Hospital.
XI. Hering Medical College and Hospital.
XII. Georgetown University, D. C.



## COMMITTEE ON INCREASING MEMBERSHIP.

*Fellow Members:* Your Committee on New Members reports that it has done some work toward urging the importance of membership in this Society upon every homœopathic physician in New York State who is not now a member, or who has not been dropped for non-payment of dues or failure to qualify for membership after election.

Of the 1406 members of the profession in last volume of the Transactions we found 829 not members, which the record showed as not having perfected membership. These names were divided up among the members of the committee in different parts of the State and a letter and an application blank was sent to each by the member of the committee closest at hand.

These applications were mailed the first week in September and up to date the committee have thirty-eight applications. Your committee is not satisfied with this showing, but hopes that at the annual meeting it may have a larger number of applications to present, as the result of further work between now and then.

Respectfully submitted,

HERBERT D. SCHENCK, *Chairman.*

## REPORT OF COUNSEL.

Opinion Relative to Delegate Members and Amendment to Constitution and By-laws of Homœopathic Medical Society of the State of New York.

It seems that the New York County Homœopathic Society and the Kings County Homœopathic Society have decided that they will pay no more dues for delegate members of the Homœopathic Medical Society of the State of New York.

What is the result of such action on the part of the societies named, and what are the rights of the state society in relation to such action?

### INCORPORATION.

The state society was incorporated, to be known as the Homœopathic Medical Society of the State of New York, by Chapter 268 of the Laws of 1862, the society being formed at a convention attended by delegates from the various homœopathic medical societies in the state. A constitution and by-laws were adopted and now govern and control the acts of the society.

Additional authority was given the society by Chapter 209 of the Laws of 1882 "to regulate and control its own membership".

### MEMBERS.

Article 2 of the constitution provides that the membership of the society shall be composed of "permanent members, of delegates from homœopathic county societies and corporate institutions or associations of this state, and of such other members as may be chosen in conformity with the by-laws".

Section 3, of Article 2, of the by-laws, among other provisions concerning "membership" provides "that each Homœopathic County Society in this state is entitled to elect for a term of four years as many delegate members of this society as there are assembly districts in that county".

It thus appears that by Article 2 of the constitution and Section 3 of Article 2 of the by-laws authority is given for recognizing as many delegate members from the counties of Kings and New York and other counties having medical societies as there are assembly districts in each county respectively.

### DUES.

By Section 1 of Article 3 of the by-laws provision is made for the payment of dues, and by this article annual dues of $3 are payable from permanent members and "from each county society there shall be due $3.00 per annum for each *delegate*, to which that society is entitled".

Section 3, of Article 3 of the by-laws provides, however, "no member in arrears (in payment of dues) shall be entitled to the privileges of membership".

From the foregoing it follows that the state society cannot compel any county society to send delegates or to select delegates for membership in the state society. If the delegates already elected fail to pay their dues, they are deprived of their "privileges of membership"; that is, they cannot take part in the proceedings had at the meetings of the state society, and their names may be dropped from the roll of membership for non-payment of dues the same as any other member. There seems no penalty upon failure to pay dues, or advantage which the state society can take, other than depriving the delegates, so selected, "of the privileges of membership"; that is, neither delegate members, nor the county societies which they represent, can be compelled to pay.

By paragraph 4 of Section 4 of Article 1 of the by-laws the treasurer is directed to report "at each annual meeting the names of such members, institutions and county societies as are dropped for non-payment of dues, and shall furnish the tellers with a list of the active members entitled to vote". And by Article 2, Section 1 of the by-laws "active members" is defined as meaning those of the "permanent delegate and senior members as are in good standing". There is no provision in the by-laws concerning the time when the delegate members shall pay their dues, or when the county society shall pay the dues of its delegate members; but from the provisions above cited, it would seem that the dues of the current year must be paid at least when the annual meeting is held; and it is, evidently, the intention, in order to allow the delegate to take part in the semi-annual meeting, that he must have then paid his dues, otherwise he would not be a member in good standing.

So that, if at your next semi-annual meeting the delegates from any county attend that meeting and are then in arrears in the payment of their dues, either the delegate, or the county society (which is primarily liable for the dues, as Section 1, of Article 3 states that the $3.00 per annum for each delegate shall be due "from each county society") must pay their dues in order to have any privileges whatever in connection with the meeting.



### AMENDMENTS TO CONSTITUTION.

Article 7 of the Constitution provides: "Any article of this constitution may be amended at an annual meeting by a two-thirds vote of the active members present, provided that a written notice shall have been given at the preceding annual meeting. Article 2 of the constitution designates the membership of the association and says it shall be composed of "permanent members, delegates, etc., and of such other members as may be chosen in conformity with the by-laws". The constitution does not define the meaning of active members, but Section 1 of Article 2 of the by-laws says: "By the term "*active members*" is meant such permanent, delegate and senior members as are in good standing."

It seems, therefore, that the constitution may be amended at any annual meeting by a two-thirds vote of the members present who are in good standing, whether permanent, delegate or senior members, provided a written notice shall have been given at the preceding annual meeting. By this it is intended that a written notice shall be introduced at the business session of the association at its *annual* meeting (not at its semi-annual meeting) of proposed changes in the constitution, to be acted upon at the next *annual* meeting.

### AMENDMENTS TO BY-LAWS.

Article 9 of the by-laws provides that "These by-laws may be amended by a two-thirds vote of the active members present at an annual meeting provided that written notice shall have been given at a previous regular meeting. The term "active members" is defined in the suggestions above noted in reference to amendments to the by-laws, and the same provisions stated above in connection with amendments to the constitution apply to amendments to the by-laws, except that the written notice that the by-laws will be amended may be given at a previous *regular* meeting, and the term "regular meeting" must mean the *annual* meeting *and* the *semi-annual* meeting. While Section 3 of Article 5 of the constitution provides for special meetings, there is no provision, either in the constitution or by-laws, as to what may be transacted at the special meeting; and it would not be safe to attempt to do so important an act as to amend either constitution or by-laws, or give the notice in writing in connection with the amendments to the by-laws at any special meeting, but proceedings to amend the constitution must be confined to annual meetings and amendments to the by-laws must be confined to regular meetings which must be *annual* or *semi-annual* meetings.

Respectfully submitted,

FRED. E. WADHAMS, *Counsel.*

Dated Albany, N. Y., Aug. 26, 1902.

## REPORT OF COMMITTEE ON ATTENDANCE.

Enrolled the following eighty-four:

*Albany County*—George E. Gorham, A. B. Van Loon, F. J. Cox, J. Ivimey Dowling.—4.

*Broome County*—L. A. Martin, C. A. Ward, E. E. Snyder.—3.

*Cattaraugus County*—Joseph Rieger.—1.

*Cayuga County*—Charles A. Gwynn.—1.

*Chemung County*—E. H. Noble, R. B. Howland.—2.

*Chenango County*—F. E. Roper.—1.

*Cortland County*—E. B. Nash—1.

*Dutchess County*—C. E. Lane.—1.

*Erie County*—George R. Critchlow, D. G. Wilcox, J. G. Chadwick, Fred D. Lewis, F. Park Lewis, George T. Moseley.—6.

*Franklin County*—J. H. Hallock.—1.

*Fulton County*—E. L. Hill, W. S. Garnsey.—2.

*Genesee County*—J. W. LeSeur.—1.

*Jefferson County*—E. A. Simonds, W. H. Nickelson.—2.

*Kings County*—J. H. Schall, H. D. Schenck, William M. Butler, J. L. Moffat, G. C. Jeffery.—5.

*Livingston County*—J. A. MacKenzie.—1.

*Madison County*—G. L. Gifford.—1.

*Monroe County*—S. R. Snow, P. W. Neefus, J. M. Lee, T. D. Spencer, W. C. Daley, C. F. Otis, W. S. Rambo.—7.

*New York County*—G. W. McDowell, Frank LeC. Dowe, T. D. Buchanan, F. W. Hamlin, W. S. Mills, J. T. Simonson, L. L. Danforth, W. H. King, C. Gennerich, G. W. Roberts, A. P. Powelson, William F. Honan, E. G. Rankin, George F. Laidlaw, Walter S. Mills, B. G. Carleton, Walter Crump, J. W. Roberts.—18.

*Niagara County*—S. W. Hurd.—1.

*Oneida County*—C. G. Capron, M. O. Terry, A. B. Southwick, A. R. Grant, L. W. Dean, C. E. Chase, E. G. Randall, N. C. Scudder, C. T. Haines.—9.

*Onondaga County*—J. W. Candee, Frederick Hooker, J. M. Keese, L. C. Crowell, J. W. Sheldon, B. F. Sherwood.—6.

*Orange County*—M. C. Ashley, F. W. Seward.—2.

*Otsego County*—A. D. Getman.—1.

*Schenectady County*—William P. Faust.—1.

*Tioga County*—J. T. Greenleaf.—1.

*Westchester County*—C. J. Miller, D. J. Roberts.—2.

*Neighboring States*—W. A. Dewey, Ann Arbor, Mich.; H. F. Biggar, Cleveland, O.; H. C. Allen, Chicago, Ill.—3.



## REPORT OF EXECUTIVE COMMITTEE.

The Executive Committee voted that W. A. Dewey, E. B. Nash and C. E. Chase be reinstated as permanent members. Also, that hereafter at the meetings of the Society each member in attendance register with the Committee on Attendance and receive a badge whereon his name and city are inscribed; that the Treasurer have his desk adjoining that of the committee in order that dues may be collected at the same time, but not as a necessary pre-requisition of the badge.

## MISCELLANEOUS BUSINESS.

F. E. Roper, of Norwich, who has been absent from the state for some years, was re-elected to membership without paying the initiation fee.

A. R. Grant offered the following resolution, which was adopted:

*Resolved*, That a vote of thanks be sent to the Board of Trustees of the Masonic Temple for the courtesies of their building and the use of their banquet hall.

J. W. Candee moved that a vote of thanks be extended to the physicians of Utica for their admirable entertainment of the State Society.

DeWitt G. Wilcox presented the bill of the Committee on Increasing Membership for postage, printing and stationery, amounting to $28.50; the same was referred to the Treasurer for payment.

The following program was carried out:

### FIRST DAY—MORNING SESSION.

## BUREAU OF GYNÆCOLOGY.

S. R. SNOW, Chairman, presented four papers:

"The Advantages of Homœopathy in Gynæcology," EMILY F. SWETT.

"Appendicitis Complicating Pregnancy," J. H. SCHALL.

"Experiences Derived from a Series of Peritoneal Operations," JOHN M. LEE.

"One of Those Peculiar Cases," DEWITT G. WILCOX.

## BUREAU OF NEUROLOGY.

P. W. NEEFUS, Chairman, presented two papers:

"An Anatomical Factor in Mental and Nervous Diseases," A. P. POWELSON.

"According to Hudson," JOHN T. GREENLEAF.

The term gynæcology is understood to mean the diseases and derangements of the generative organs of woman incident to one of these periods, not only in the degrees which send her to the specialist, but in all degrees presented to the general practitioner.

The glamor attendant upon operative procedures in the domain of gynæcology during the past few years, has had the very undesirable effect of obscuring to a certain extent the medical treatment of diseases of women. But the inevitable reaction has set in, and conservative physicians the world over are endeavoring to restrict surgical operations to those cases in which medical treatment has been intelligently, persistently but unavailingly applied. It is from the family physician that we gather the most reliable data of the curative power of homœopathic remedies. Therapeutic means are most marked and definite in their effect upon functional derangements and the early manifestations of disease. With these early derangements the family physician has to deal.

From evidence gathered, we are justified in our claim that a large proportion of functional derangements of women are speedily and perfectly cured by homœopathic remedies, and that many pathological changes to which the uterine organs are subject are by these means prevented, or cured at their very outset. There is no question but that our medical treatment is doing for our patients more than they or even we realize, in preventing disease, or curing it in its incipiency. If it were possible for us to compare a list of our patients with a like number differently treated, the validity of the claim that women who have been under homœopathic treatment from their childhood are much less liable to uterine diseases, could, without a doubt, be easily demonstrated.

Little wonder that our old school brethren doubt our claims, when they seem to have lost faith in nearly all drugs, as is evidenced by their almost exclusive reliance upon opiates to deaden sensibility to pain, tonics to stimulate nature's efforts and alteratives to disturb existing functional derangements, hoping for the evolvement of an improved condition therefrom.

In striking contrast is the picture which the mere mention of such remedies as belladonna, cimicifuga, colocynth, sepia, pulsatilla, bellis, helonias, fraxinus, thuja and a score of others brings before those of us who have had any considerable experience in the homœopathic application of remedies.

It is safe to assert that in the practice of homœopathic gynæcology a large proportion of the cases which, under old-school treatment would remain uncured, or be subjected to operation, are cured by homœopathic medication. Even in those cases demanding surgical treatment, by combining our medication with the mechanical means, many pathological conditions are cured, as uterine displacements, ovaritis, pelvic peritonitis, metritis, fibroid tumors, salpingitis, and even ovarian cysts. The powerful influence exerted by our remedies over the pelvic circulation, as demonstrated by the results obtained when they are prescribed for disturbances of the menstrual function, justifies a reliance upon their ability to control hyperæmia and



hypersecretion of the mucous membrane of the genital tract. Not a few of them have had the privilege of relieving patients who have sought for help in vain from old-school physicians, and our success was due, not to the fact that we were better mechanics than they, but because we had powerful remedial agents that they knew not of.

The scope of the application of our remedies is not to be limited by pathological conditions which promise no hope of curative results, but it is broader and wider than this. We may still hope to relieve when our pathological knowledge gives us no hope of effecting a perfect cure.

A careful study and the further development of our materia medica may add to our resources, so that what now seems impossible may be readily accomplished in the future. Failure to cure by our materia medica ought to be the exception in all non-surgical diseases of women, and when other means are resorted to they should be looked upon as palliative rather than curative. There are instances where it is judicious to palliate, but it has come to be true that the too free use of palliatives has brought upon homœopathy a slur and a reproach. What was good and effective in the hands of our master homœopaths fifty years ago should be just as effective to-day. They cured their cases at the expense of great labor. We should do better with our modern labor-saving and brain-saving devices, remembering, too, that the more extended our resources the greater our responsibility to use them judiciously. If we are but awake to our opportunities, and recognize the fact that gynæcology has opened a broader way for pure homœopathy we shall, by close prescribing before and after operative procedures, secure larger and more enduring ends. We shall find the range of our law as applied to gynæcology greatly enlarged by further drug-proving and by carefully attested clinical evidence, and thereby stamp upon science the limit of surgical measures, and at the same time make those surgical measures far more brilliant.

All arts are capable of further development, and the healing art is no exception to the rule. Indeed, we may believe it capable of unlimited development, but this capacity implies adherence to the inductive methods of Hahnemann.

We look at the sunlit clouds and know that a glorious brightness lies beyond them. We consider the brilliant achievements of homœopathic drug prescribing and believe that they but forecast the homœopathy that is "expansive, progressive, science-fostered, science-fostering and world-conquering."

# APPENDICITIS COMPLICATING PREGNANCY.

J. HUBLEY SCHALL, M. D.,
BROOKLYN.

Up to within a few years every inflammation on the right side of the female pelvis was invariably looked upon as being due to disease of the uterine adnexa.

In 1894, Dr. Munde was one of the first to publish a case of pregnancy with appendicitis, which was successfully operated upon by himself.

Two years later Dr. Abraham, of New York City, reported seventeen cases, in twelve of which the diagnosis was verified by operation. Seven of these patients died.

The difficulties of a differential diagnosis are often considerable when the right parametrium is involved, presenting a sensitive mass close to the uterus.

A long appendix lying in close relation with the uterine appendages is not infrequent. The appendix, after frequent attacks, often becomes adherent to adjoining structures; on two occasions the appendix was found glued to the right ovary. In such instances conditions are produced that the examining finger cannot differentiate from those brought about by suppurative processes that have their original seat in the tube or ovary; or, an appendicular abscess may have burrowed down to the vicinity of the uterus from above; or, finally, an appendicular infection may have directly communicated itself by contact to the uterine appendages, as shown in an autopsy where a ruptured pyosalpinx communicated with a gangrenous appendix. But even in these complex cases a careful observation will often elicit the true state of affairs. The history of previous attacks will give a hint one way or other.

However, as the size of the uterus increases, crowding aside the other viscera, a diagnosis is impossible outside of an exploratory incision.

The prognosis in appendicitis occurring during pregnancy depends upon the extent of the inflammation, the stage of pregnancy, and upon the time and technique taken to combat it.

In a certain number of cases a carefully prescribed remedy would probably be the proper treatment to pursue, were we always able to identify the mild cases. Here lies the great difficulty. The mortality among the bad cases is very high, as shown by Dr. Abraham's report. The histories of all these cases show that the operations were performed late.

Dr. Gerster, of New York City, says that "operation for the earlier stages of appendicitis presents no great risk in early or late pregnancy. Indeed, the safety of both mother and child will be increased by nothing better than radical means directed toward the removal of present or future danger lurking in a diseased appendix."



An important matter to be considered is the method of treating the abdominal wound. If the abdomen is securely closed by suture, parturition may be completed without hindrance to its own progress or damage to the suture.

On the other hand, when it is necessary to drain the abdominal cavity, the situation is a serious one. When labor sets in adhesions may be ruptured and general infection of the peritoneum occur. This is not all. The viscera may bend to escape from the abdominal cavity during expulsive efforts.

Having all these difficulties staring me in the face it was hard to decide what course was best to pursue in the five cases which have come under my observation.

However, in the two cases cited in this paper the high pulse, vomiting, the characteristic local pain spontaneous and on pressure, with the well known facial expression, made us decide that something radical had to be done at once.

Patient, aged 23 years, gave a history of frequent attacks of appendicitis before her pregnancy. When called to see the patient it was stated that within the past two days the old symptoms pointing to an appendicitis had recurred more intensely than heretofore. Upon examination the abdomen was found occupied by a uterus which seemed to be about the seventh month of pregnancy. The right rectus was rigid, and on pressure an acute lancinating pain was experienced in the region known as McBurney's point. Pulse, 138; temperature, 100½°. The rapidly rising pulse, the vomiting and characteristic facial expression decided an immediate operation. An incision was made along the outer border of the right rectus muscle, the periosteum being excised, exposed the pregnant uterus which was gently pushed aside. The appendix was found deep in the iliac fossa. It was much congested and distended with a fluid resembling weak coffee. Near its base was a marked stricture. The mucosa presented two necrotic spots. The appendix was ligated close to the gut, excised and the stump cauterized with crude carbolic acid.

The abdominal wound was then closed with the greatest care. Close rows of silk worm gut sutures were used. An aseptic dressing was applied and supported by adhesive straps with a carefully adjusted abdominal binder. The patient made an uneventful recovery and was finally delivered of a healthy infant. After delivery the abdominal wound was examined and found in good order.

The following case is one where remedies bridged the patient over former attacks, yet she was never free from pain during or after her pregnancy.

Mrs. P., aged 22 years, primipara, was admitted to the hospital for the purpose of being confined. Upon taking her history it was found that before her pregnancy she suffered considerably from "cramps" in the abdomen. The attacks followed indiscretions in diet. At the height of the paroxysm she was much nauseated and vomited a dark greenish fluid. Remedies relieved the attack and improvement

slowly followed. Since her first severe spell of colic she says she has been troubled with more or less soreness in the abdomen, especially marked on the right side. During her pregnancy the attacks have become more frequent and the pain excruciating. At times a miscarriage was feared. After careful consideration it was deemed wise to pursue a waiting policy. Under close observation, medication and a selected diet, the patient went on to full term and was successfully delivered of a healthy child.

About four weeks after leaving the hospital, the child being about seven weeks old, this patient was suddenly seized with severe abdominal pain, she vomited a greenish fluid, then broke out in a cold sweat. After taking some home remedy for cramps the pain subsided and she fell into a sound sleep.

Being much concerned about her condition she presented herself at the hospital where the case was referred to me. When seen she was suffering from severe pain all over the abdomen, which was associated with general abdominal tenderness and decided rigidity of the abdominal walls, but more severe in the right iliac region. Palpation over this area never failed to ilicit tenderness, though the appendix could not be made out.

Operation was advised and agreed to. On the morning of April 19th, after the usual abdominal toilet, etc., the patient was anæsthetized and the "grid iron" incision of McBurney was made. Upon opening the peritoneum a mass of adhesions was encountered, which were ligated and incised. After some difficulty the appendix was located deep in the right iliac fossa. On withdrawing the appendix the ovary and tube were found adherent to it.

The ovary was in a state of cystic degeneration and the tube much indurated. The appendix measured seven inches in length and was distended by cystic fluid. The appendix, ovary and tube were ligated and excised and the stumps cauterized and carefully covered with peritoneum. The abdominal wound was closed by separate sutures and supported by a series of adhesive straps and a snug abdominal binder.

Uneventful and prompt recovery followed and the patient was discharged cured fourteen days after operation. (Applause.)

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## DISCUSSION.

S. R. SNOW: Dr. Schall has brought before us, I think, an important subject. In the last few years it has become a well-authenticated fact that we often get appendicitis and ovaritis combined. It would seem to resolve itself into a question whether it is safer for the mother and the child to undergo an operation before the term of pregnancy is completed or to defer the operation. And that resolves itself into the question whether it is dangerous to the fœtus to perform an operation during pregnancy. I am sure there are some of us here who have had those cases, where operations have been performed during pregnancy, and we should like to know their experience, in the discussion of this paper.



J. H. SCHALL: *Mr. President*, I believe Dr. Snow has a case under observation at the present time. I think it would benefit the Society to hear a little something about that case.

S. R. SNOW: *Mr. President*, With Dr. Terry here, I can scarcely stand up and say I have had a case of appendicitis and did not operate on it. During the last two years I have had two cases of pregnancy complicated with appendicitis. Neither of them was in the suppurative stage, but in the sub-acute condition. Consequently I let them alone, and both were delivered of their offspring, one case about five weeks ago, and she had considerable digestive disturbance, more so than the usual case during pregnancy, and it is only a question of time, to my mind, when that appendix will give her more trouble. The other case is now in good condition.

M. O. TERRY: *Mr. Chairman*, in order to stir up my friend Roberts, my friend Wilcox, from Buffalo, and others who are present, I can give the history of one case, which was reported two years ago, in a collection of cases, of considerable interest, as it was rather a test case in the line of thought of this paper. This woman was seven months along and had an appendicitis of so great intensity that the question of operative procedure was discussed, as a final resort the conclusion being the only thing to do to save the woman's life. It was under old-school treatment, and consultation was had, including, I think, seven doctors. I think two were from the great and glorious city of New York. It was given out at this hospital that there was an oil treatment that had been used in Albany—and this case was in Utica, which was a great treatment—and so I was known in Utica by way of Albany. (Laughter.) This woman came to me and wanted to know if I wouldn't go up in consultation. I said I didn't care for that sort of case because I had a very good record and I wanted to keep it, fearing that Wilcox and Roberts would get hold of it, you know. (Laughter.) However, tears were successful, and I went to this hospital, which I do not attend regularly, and the case was turned over to me, although I requested the doctors to make an effort to cure the case without operative procedure. Well, for two days I made no progress whatever. Nothing could be taken, nothing could be held, and nothing could be done for the woman. In the meantime the fœtus was being starved. The second day I told this old-school doctor I thought perhaps we better operate. I didn't want to take the case in the beginning. He wouldn't touch the case then, anyway. "Very well," I said, "Doctor, you are invited to the post-mortem." That evening the woman had a miscarriage and the fœtus came away dead. "Well," I said, "now I think I can show my dexterity with the oil treatment." In four weeks the woman was well. This was, I think, three years ago, and she has remained perfectly well. I don't know whether that appendix was gangrenous, whether she had an abscess—I don't know whether it was impossible to save her or not, according to our surgical friends here, but the woman is alive and has never had an attack from that day to this.

Her husband is in business about fifty feet from my office, if any one questions my veracity. Now, I am not advocating that sort of a treatment, gentlemen. I am simply telling you what can be done. There is one surgeon here, one of the younger surgeons of our school, who came to Utica with the most heroic ideas a few years ago, having been educated under Morris, the College of Physicians and Surgeons, &c., and I do not think he had the faintest idea that you could do such things. Now there is danger of his going too far the other way. That is the only fear I have. Now, when such results can be obtained under that treatment it shows what surgeons can do all over the country in this interval when patients won't allow you to operate. I say I am not advocating this conservative method to take the place of the surgeon's knife absolutely; but where they do not allow you to operate, in that interval, if you understand this principle, if you carry it out in detail, everything pertaining to what we call the oil treatment, it means a good deal. It takes better judgment, it takes more brains to carry a case through with this treatment than it does by the use of the knife. I think Dr. Grant can give you some of his experience which will be interesting, for he is the surgeon I referred to previously. As I said, I am not running the surgeons. I belong to that class myself and have tried to make myself a fairly good surgeon. The profession has not understood me at all, and the only chance I have had to get a whack at them was at Buffalo last September.

E. B. NASH: What remedies do you use in conjunction with the oil treatment?

M. O. TERRY: I would like to say to Dr. Nash that I do not think the remedies amount to the snap of your finger in regard to the oil treatment unless used with it. I give aconite for the inflammatory condition; I give bryonia, belladonna, and I give what I would call the indicated remedy in perceptible doses. I give phenacetin at times. But remedies such as aconite, veratrum veride, bryonia and belladonna are the chief ones to be depended on. I gave calomel and soda in the case I referred to for its resolvent effect. Now, I have a reason for everything I do, gentlemen, in this disease. You can ask me all the questions you desire and I am perfectly willing to answer them, but I do not wish to take up the time in this convention.

S. R. SNOW: I am afraid if we should get into a general discussion of appendicitis in the gynæcological bureau we wouldn't do anything else. Dr. Terry's treatment is very fully described in the minutes of last year's meeting. I am sorry that Dr. Terry's oil treatment did not save the fœtus in this case. (Laughter.) I think the important part to us is the pregnancy side of the question, not the appendicitis, and that is what I would like to have brought out in the discussion—what the effect of the operation is upon the fœtus. We will take care of the appendicitis side when we come to the surgical bureau.

E. B. NASH: *Mr. President*, the only reason I asked that question in regard to the remedies used in conjunction with the oil treatment was this, we sometimes hear of cures combining different kinds of treatment, or recoveries occur under them, and we hardly know which to attribute the cure to. I believe, yes, and I know, that in the great majority of cases this appendicitis is perfectly curable, and many times even after pus has formed; but I can see no objection whatever to combining the oil treatment with the medical, and I do not see how it can possibly interfere with it.



G. W. ROBERTS: *Mr. President*, It seems that the distinctive feature of this paper, practically the only thing, is the question as to whether it is wise and safe to operate upon a pregnant woman. That is, is it safe as to the production of miscarriage? Of course, we know that we can very frequently operate upon a pregnant woman, do abdominal and other operations without the production of a miscarriage. At the same time there is a very large element of risk. The doctor has reported two cases in which he operated without producing a miscarriage. I wish to state that I have made abdominal operations on three or four occasions on pregnant women, and in nearly all cases my operation has been followed by a miscarriage, notwithstanding the fact that miscarriages occur after so slight a procedure as the amputation of a finger, and after the opening of a small abscess on one of the extremities. Now, it is quite possible that I have had a run of bad luck so far as this particular class of cases is concerned, but my own experience does not correspond with the idea that it is comparatively safe to do a major operation upon a pregnant woman.

PRESIDENT MOFFAT: I would like to ask if any one present can help us out with a suggestion about the mode of anæsthesia, the antiseptic used, or the degree of anæsthesia, whether that had anything to do with the effect upon the uterus afterward.

DEWITT G. WILCOX: *Mr. President*, My observation is that a pregnant woman takes chloroform very safely indeed. I was about to make the same remark that Dr. Roberts has just made, to the effect that it is remarkable what the pregnant woman will undergo in the way of an operation safely without a miscarriage. I wish to say further in answer to your question, Mr. President, that probably in the majority of cases the pregnant woman will take chloroform rather better than ether. And yet, as Dr. Roberts says, there is always a large element of risk to consider. At the same time, if the patient were in immediate danger because of the pelvic condition, I should consider it wise to operate rather than to delay the operation simply because of the pregnancy.

J. H. SCHALL: Some time ago I spoke to Dr. Fowler, of Brooklyn, concerning this subject. He is more or less dubious concerning the prognosis of cases operated for appendicitis occurring during pregnancy. A prominent Hebrew doctor of New York has just delivered a woman of twins who was operated for suppurative appendicitis at her fourth month of pregnancy. According to the last report the mother and twins are doing well. This is an interesting case. I believe a record of it is published in one of the journals.

# EXPERIENCES DERIVED FROM A SERIES OF PERITONEAL OPERATIONS.

J. M. LEE, M. D.,
ROCHESTER.

In the last report of our *Private Hospital*, recently issued, we state: "There were 927 operations performed, an increase of 337 over our last report, and the majority of them were classed as capital. Among those, fifty-three were for appendicitis; one exploratory operation; one for abdomino-colonic fistula; one for abdomino-vesical fistula; one each for cancer of the sigmoid flexure of the colon and of the stomach; one for chronic peritonitis; one for chronic puerpal septicæmia; one for double pyosalpinx and ovarian abscess; two for enucleation of broad ligament cyst, from pelvic floor; five for extra-uterine pregnancy; one for liberation of adhesions, retroverted uterus, displaced tubes and ovaries; two for obstruction of bowels; one for ovarian abscess; two for perforated intestine; one for peritonitis and pelvic adhesions; one for post-operative fistula; one for acute puerpal peritonitis and pelvic adhesions; two for resection of portion of diseased ovary; two for ruptured ovarian cyst; twenty-five for pyosalpinx, cystic or infected ovaries; one for sarcoma of mesentery; one for secondary hemorrhage; one for septic peritonitis; one for suppurative peritonitis; two for umbilical hernia and pendulous abdomen; three for ventral hernia; twenty-eight for retroversion, diseased appendages, ventrofixation; one for removal of gall-bladder; four for cholecystotomy; three for cholecystendysis; three for choledochotomy; one for choledocho-lithotrity; one for closure of fistulous opening into rectum and iliac fossa; four for colotomy; seventeen colpotomies for pelvic abscesses, and minor diseases of the tubes and ovaries; two for excision of cancerous portion of sigmoid flexure of colon; one for gastrostomy; three for abdominal hysterectomy; nineteen for hysterectomy abdomino salpingo-oopherectomy; one for hysterectomy abdomino-vaginal; four for hysterectomy abdomino-vagino-salpingo-oopherectomy; one for hysterectomy and removal of extra-uterine pregnancy sac; fifteen hysterectomies, vaginal; two for hysterectomy, vaginal, by morsellment; two for hysterectomy vagino-salpingo-oopherectomy; six for myomectomy, abdominal; three for myomectomy, vaginal; seventeen for ovariotomy, single; fifteen for ovariotomy, double; one for ovariotomy, double, with closure of fistulous opening into rectum and ilium; one ovariotomy, vaginal, and two for extirpation of rectum, entire, for cancer.

We will make reference to but a few of these cases. Among the fifty-three operations for appendicitis there were two deaths where perforations of the appendices occurred while the patients were about their business. They were received with blood poisoning which terminated life, notwithstanding the operations.



Several years ago at the meeting of the American Institute, I believe at Atlantic City, Dr. J. H. MacClellan, of Pittsburg, called attention to the frequent complication of diseases of the uterine appendages with appendicitis, and suggested that during the years to come, all of the surgeons when making abdominal sections for other diseases than appendicitis, examine the appendix that they might determine as to whether this organ is diseased secondarily by infection from the tubes and ovaries and vice versa. Last year at the meeting of the above body at Richfield Springs, my esteemed colleague and classmate, Prof. Jas. C. Wood, read a lengthy and interesting paper bearing upon this subject in which he showed clearly that inflammation of the appendix occasionally spreads to the pelvic organs of the female and causes destructive or even fatal complications and in growths or primary phlegmons of the internal genitalia, the inflammatory process very often reaches the appendix and renders double operations necessary with their increased dangers.

That masterful female surgeon, Dr. Florence Ward, of San Francisco, California, has published a similar paper and many other men and women throughout the country have given to the profession the results of their experiences in this line. It is now quite well understood, though I do not think the profession at large realize how common it is that diseases of the uterus, appendages and appendix are associated.

In my own work during a comparatively brief period, I have encountered twenty-eight different phases of disease co-existing with maladies of the appendix, uterus, tubes and ovaries. It is mostly in infection that disease spreads in the pelvic tissues, but in all operations in the abdomen, we should be exceedingly careful to examine thoroughly everything that can be brought in sight; and the one who practices this will be often surprised at the number of conditions present which might keep up pain and invalidism, even after the major disease is apparently removed. This is the most potent argument against the wholesale employment of vaginal sections to relieve disease in the pelvis; for, not infrequently, there appears to be nothing more serious than a small ovarian cyst which can be removed readily per vagina, yet an abdominal operation might enable the surgeon to find also the appendix adherent and elongated from constant traction from the weight of the cæcum, which is really the cause of the woman's pain. Again, bands of the omentum or coils of the intestine are adherent in such a manner as to keep up constant traction and suffering to such an extent as to render the patient quite hopeless without the correction of these defects. Indeed, the twenty-eight different forms of disease discovered in the abdomen while operating for other distinct and known diseases, had to be corrected else the results of the operations would have been imperfect if not absolute failures. It is these conditions,

too numerous to mention here, which should discourage the busy surgeon from frequent use of the vaginal route. For, how can he expect to be successful if he removes a small suppurating ovary, a pyosalpinx or a small fibroid tumor and opens an intestine, a fistulous tract, or ruptures a vessel which is overlooked and neglected? The patient's life is sacrificed by these complications which might have been avoided by daylight and plenty of room from above.

Where this direful result does not follow, too frequently life is made unendurable by mutilated tubes and ovaries, dragging adhesions or exhausting discharges which could have been readily reached by a free abdominal incision.

I apprehend that vaginal section has about exhausted itself as the usual procedure in pelvic diseases and that it has received its appropriate and limited sphere of usefulness. At any rate, we, as surgeons, must make sure that in our zeal to bolster up any original or new theory, we do not jeopardize our efficiency and reputation by a senseless attempt to support any peculiar notion or fad.

Of late I have completely changed my methods in the treatment of cholelithiasis where the gall-bladder is healthy. Formerly it was my custom to stitch this organ to the skin, as taught by Tait, but as these cases often required a second operation, even when the common duct was patent, to close the fistula, I abandoned this method in favor of stitching the gall-bladder to the muscles and facia. This generally permitted the wound to close after a time, though not always, and occasionally led also to second operations. With my past twelve cases, in three of which the gall-bladder and common ducts were both opened for the extraction of impacted calculi, the wound in the cyst and ductus communis choledochus were both closed, the toilet made and the parts dropped back. When the disease could be completely relieved by cystotomy of the healthy gall-bladder alone, the same plan was followed, cholecystendysis, and the abdominal wound closed as usual, though the gall-bladder was not anchored to the under surface of the abdominal wall.

All of these cases recovered with no more distressing symptoms than is usual with ordinary abdominal sections. The technique employed is not so complicated as that described by most writers; therefore, a brief description is given: An incision is made from the cartilage of the tenth rib downward, and slightly inward, of sufficient length to permit of easy access to the parts. The wound is retracted, adhesions are divided, if any, the site of operation walled off by large gauze pads which surround the gall-bladder, when, if large, it is tapped with a rectal trochar and as much fluid drawn off as possible. Then it is opened from the trochar mark downward sufficiently to permit of easy access to its cavity, the organ carefully dried out with bits of moist cotton, the soiled sponges removed and replaced by fresh ones, then the concretions are extracted from the gall-bladder and its ducts. If the common duct is occluded it is grasped by the thumb and finger and brought up, or it is pressed forward by the handle of a retractor until the index finger can be



insinuated behind it directly under the calculus to be removed. Then the duct, with its calculus, is pressed forward and held in this manner while with the right hand the operator incises the wall of the duct directly over the stone and presses the concretion out through as small an opening as possible. Care must be taken not to wound the large vessels in this site. A curved needle armed with small black silk is then passed from the peritoneal surface through the lips of the incision in the duct, taking care not to permit the end of the needle to perforate the mucous membrane, but to pass down to it and through its outer border, if possible, and out the opposite side through the corresponding tissues and tied. This thread is to be used as a continuous suture, and care should be taken to pass the needle each time as just described until one row of sutures is in place. When the wound has been brought together nicely in this manner the operator returns with a second row over the first, using the same thread and taking up considerable peritoneum in the grasp of the needle, so as to bring a thick fold of this structure over the first row of sutures. When this has been done, if it is clear that the wound is thoroughly secured against leakage, the two rows will be sufficient, but if there is any question as to this feature of the work, a third should be carried from a little below the lower end of the second to a point just above the upper end of it, the suture tied, after which the opening in the gall-bladder is closed in the same manner by two or three rows of buried silk sutures. The toilet is made, the abdomen closed and recovery is not unlike that from ordinary intra-abdominal work.

The only other portion of this work to be commented upon is *cancer of the rectum*. For several years past I have practiced extirpation of this organ by Kraske's plan, by the old-fashioned method, modified, in males, by laying the vagina and perineum open down to the rectal wall, in females, and when none of these methods were applicable colotomy has been resorted to usually in advanced cases.

First, then, *extirpation of the rectum through the vagina:* As stated in my first report "This organ is better resected through the vagina than though the sacrum as in the method of Kraske. An incision is carried from a point just behind the os uteri down to the sphincter ani, then a circular cut is made around the anus. If the sphincter is not involved by the growth it is divided and carefully preserved, but if diseased it is removed. The wall of the rectum, with the cancer, is carefully dissected from the sphincter, and the vagina turned back to the right and the left by a few strokes of the knife. The rectum, with its cancerous mass, is lifted from its cellular bed, by finger dissections, accompanied by occasional division of fibrous bands with the scissors or scalpel until the levator ani muscle is reached and brought into view. This is a thin, fibrous, muscular structure which forms the floor of the pelvis and is attached to the rectum all around its surface. When viewed from below it resembles an inverted umbrella, and before the pelvic cavity can be opened for this operation, the levator ani muscle must be incised all around with the scissors when the rectal peritoneal fold comes into plain

view. Should it become necessary to open the pelvic cavity, in order to liberate enough of the rectum to make the resection and intestinal suture without tension, no difficulty whatever is encountered at this step, as the vaginal method enables one to see the peritoneal fold of the rectum, anteriorly, more clearly than is possible to see the utero-vesicle fold in the somewhat analogous operation of vaginal hysterectomy and it is more readily stripped off. This is not the case in Kraske's operation, but in either of them great care must be taken not to cut the inferior mesenteric artery, for this accident would probably destroy the blood supply, cause the end of the intestine to slough, and might thus spoil the operation or destroy the life of the patient. The wounding of the artery may be avoided if the posterior dissection is carried up in the cellular tissue at some little distance back of the rectal wall. Generally the artery can be plainly seen and shunned. In somewhat advanced cases there is a row of enlarged lymphatic glands which accompany the artery and must be removed. Great care must be exerted in this manœuvre, also, else the inferior mesenteric vessels be wounded.

The extent to which this operation is carried depends upon the site of the cancer. If it be located at the anus and runs up the rectum not more than three inches, there is no necessity for opening into the pelvic cavity; but if it goes beyond this point the peritoneum will probably have to be stripped off, then carefully incised by the scissors each side of the intestine, in order to render the rectum sufficiently slack to permit the cut healthy end to be sutured to the skin without tension to form the new anus.

If we have an anular cancer to deal with in a female, situated from two to four inches from the anus, the technique is the same, except that the sphincter ani is always preserved and the rectum loosened and drawn out of the pelvis through the vagina to make sufficient slack exactly the same as in Kraske's operation; then a strip of gauze is tied about the intestine considerably above the point at which the upper section of the rectum is to be made, to prevent fecal infection from the wound. The piece of rectum which contains the cancer is resected and the cut ends sutured with black silk exactly as in the last-named operation. The gauze is now removed from the intestine, the peritoneum stitched to the rectum above its former attachment and the vaginal wound closed; care being taken to nicely coapt the cut ends of the sphincter ani. The operation is done in the lithotomy position by good light and the sense of touch, the peritoneal cavity is more easily closed by suture than in Kraske's operation and all other steps are more easily executed than is possible by the sacral route.

In the male an incision is carried backward from the anus to a point well up along the side of the coccyx and sufficient room gained to easily dissect out the rectum and open the peritneal cavity. If it is found that sufficient slack cannot be gained to bring the intestine down and form an easy union of the intestine to the cutaneous borders to form a new anus, an abdominal section may be made,



the rectum and a portion of the sigmoid flexure of the colon removed entirely and the cut end of the intestine brought up and stitched to the skin of a small wound made in the usual right colotomy position to form an artificial anus, as described by our distinguished member, Dr. Roberts, of the New York College. Then the peritoneum is stitched together, along the old site of the sigmoid flexure of the colon and the rectal and the abdominal wound closed without drainage if good hemastasis has been secured. The rectal wound is dressed and drained through the former site of the rectum and allowed to close partly by primary union, and partly by granulation.

We cannot at this time further comment on these 276 operations in the peritoneal cavity. They include all the work of this character done in our private hospital during the past two years, though many others of similar nature have been performed in other hospitals and in the homes of the people. Of the latter I have at present incomplete records and therefore cannot give the results, but the mortality of the above 276 operations is 5.7 per cent., including the moribund patients. Without them it is 2.5 per cent.

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## ONE OF THOSE PECULIAR CASES.

DEWITT G. WILCOX, M. D.,
BUFFALO.

My contribution consists in the relating of a case somewhat unique, which carries with it a few points of interest and instruction. Less than a year ago I saw in consultation a young girl aged fourteen years, who was well developed, of robust appearance and apparently possessed of the best of health, aside from the local condition about to be related. Three months previous the family physician was called because of pain which the patient was having midway between the umbilicus and symphysis, extending latterly in each direction. Pressure over McBurney's point elicited rather more pain than elsewhere. Her temperature at that time was 99.5; pulse, 120. For some days prior to the physician's call the patient had kept the right thigh flexed upon the abdomen when lying down, and when standing would lean forward to obtain relief from pain. Her bowels and stomach seemed to be acting normally but the bladder was quite irritable, requiring frequent evacuation. The physician naturally concluded she was suffering from a mild attack of appendicitis and so treated her for two weeks; during that time there was constantly present a fullness in the right illiac region, which was somewhat but not acutely tender.

At the end of two weeks the temperature and pulse were normal and the patient very comfortable, but the fullness, like the "Star

Spangled Banner," was still there. He dismissed his patient and did not see her again for a month, during which time she was quite well, with an occasional attack of right-sided pain near McBurney's point, when he was called to find her suffering with the same set of symptoms, only rather more acutely. I saw her a few days later with a condition about as follows:

Pulse 110, temperature 99.6, in good flesh, feeling cheerful, but a general discomfort throughout the abdomen. I found this latter quite decidedly distended, dull on percussion and a little tender throughout, but more marked on the right side; had been having daily bowel evacuations. The abdomen was too generally distended to permit of my discovering any tumefaction in the right side.

Upon inquiry of the physician I learned that she had menstruated once only, being but fourteen years of age. It was difficult to arrive at a very satisfactory conclusion as to the precise nature of the disease or the organ affected, yet the symptoms seemed to indicate that the appendix was the structure primarily at fault. I could not, however, believe that the distension of the abdomen was due to the accumulation of pus therein, because of the absence of any decided sign of peritonitis or septicemia. Yet it seemed best to open the abdomen and ascertain what was at fault. This I did, choosing the right illiac space for my incision rather than the median. As soon as the peritoneum was opened there gushed out an enormous quantity of reddish black fluid resembling venus blood and serum. I should estimate there were two quarts of this fluid. After this was evacuated I made a careful examination of the abdominal and pelvic structures. I found the appendix perfectly normal, giving all appearances of never having been inflamed in the least. Both fallopian tubes were large and at their fimbriated extremities there was exuding more of this same dark fluid. The uterus was as large as a four-months' pregnancy. This latter, together with the bloodly fluid escaping from the tubes, was the determining point in the diagnosis.

The question was again raised as to whether the young patient had ever menstruated and the mother was called in to answer. She affirmed that the daughter had never had the slightest show of a menstrual flow. In this the family physician had been in error, as he had understood she had menstruated once. The abdomen was then thoroughly washed, to free it of all the bloody fluid which it contained, and the abdominal incision temporarily closed. The patient was changed to the lithotomy position for the purpose of making a careful inspection of the parts. The causative factor in the production of the whole trouble became then instantly apparent, which was an imperforate bulging hymen. This was quickly incised and there escaped the accumulated menstrual blood of many months production.

The vagina of the little patient was extended to such an extent as to push up the uterus almost above the brim of the pelvis. I should estimate that at least ten ounces of menstrual blood was contained in the vagina alone. I then dilated the cervical canal of the uterus moderately and again passing my hand into the abdominal cavity



I pressed out from the uterus a quantity of accumulated menstrual blood. The patient made a rapid recovery and has since menstruated regularly.

It is very apparent that the effort on the part of the uterus to force the menstrual blood from its cavity resulted only in filling the vagina as full as it could hold. As there was no external outlet for this fluid, nature sought to relieve the uterus of its burden, by finding an exit through the open ends of the fallopian tubes. This explained the presence of the fluid in the abdomen and the resulting distension and dullness discovered later. The pain was undoubtedly due to the distended tubes and the constant efforts of those organs to force out the blood which the uterus was so unkindly putting upon them. The greatly enlarged uterus was, of course, due to the accumulation of the menstrual blood from which it could not further free itself. The temperature and rapid pulse might have been due to a slight pelvic peritonitis caused by the presence of the fluid therein.

The moral is that the surgeon cannot be too careful in examining his patients in every respect before operating, however clear the indications may be pointing to a certain condition.

In the above case, while it was really essential that the abdomen be opened for the purpose of removing the accumulated fluid, yet the cause of the difficulty was not ascertained until after the imperforate hymen was discovered. (Applause.)

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## DISCUSSION.

L. L. DANFORTH: *Mr. President*, The case which Dr. Wilcox has reported is certainly very interesting and rather peculiar. It reminds me of a similar one which I saw many years ago, with the late Dr. Theodore D. Bradford, of New York City. The patient was a young woman about seventeen or eighteen years of age who had never menstruated. She had no such severe abdominal symptoms as in the case narrated by Dr. Wilcox. But her health was poor. She suffered from pelvic pain, often severe, and generally expulsive in character. As menstruation had never appeared, and there was a gradually increasing enlargement just above the pubes, which could be distinctly defined, pregnancy was suspected by some physicians who had been consulted. An examination under ether revealed an absolutely imperforate hymen. When this was incised and the parts dilated a great quantity of black, clotted blood was discharged; the vagina was distended and filled with it and so was the uterus, and it was this accumulation which caused the distress and the uterine enlargement; the cavity of the uterus was distended by the retained blood. One can easily imagine how such an accumulation might dilate the fallopian tubes, and discharge into the abdominal cavity.

W. S. GARNSEY: During the first year of my private practice I had a case of imperforate hymen in a colored girl, with the resulting flow

of dark blood from the vagina upon incision of the hymen, though there were no abdominal symptoms; and I would like to ask Dr. Wilcox why the peritoneum, which is capable of absorbing so readily any aseptic fluid, should not have disposed of the blood which escaped through the fallopian tube.

H. C. ALLEN: I would ask Dr. Wilcox why he didn't examine the hymen before he operated. (Laughter.) He certainly is one of the best diagnosticians in our school. I should have thought he would have done that.

G. W. RORERTS: I want to answer that for Dr. Wilcox, or rather for the medical profession in a way, and at the same time make a criticism of one of the attitudes which we assume that I think is wrong. There is a very strong prejudice among the medical profession, as well as among the laity, against the digital examination of young girls, and that such a prejudice should exist is somewhat right. At the same time we must remember that the hymen means nothing. It is no evidence of any sort; and we must also remember that when it comes to destroying an affair which is of no use and is no evidence, for the purpose of making a diagnosis of a condition which jeopardizes life, there can be no doubt as to our duty. I believe that we are avoiding the pelvic examination of girls altogether too much at the dictation of public opinion; and while I do not believe in indiscriminate examinations of that sort, it is rarely that an abdominal condition can be thoroughly weighed up without a careful bi-manual examination, and personally I never hesitate to state to the patient, or the family, the valuelessness of the hymen and advise a pelvic examination. I think that Dr. Wilcox did what the majority of us would have done under the circumstances. He had a very clear indication for another condition. He probably felt comparatively sure of his diagnosis, as we often do, by abdominal conditions, and he wished to protect his patient from the discomforts and other disadvantages of a pelvic examination, and most of us would have have done the same thing.

W. H. NICKELSON: *Mr. Chairman*, I am in the habit, when I have occasion to examine a young girl like that, not to examine through the vagina but through the rectum. You can find out nearly all you want to find out through the rectum, and I think in a case like this, by passing the finger into the rectum you can very easily discover whether the vagina is full of blood and whether the case is one for abdominal operation.

GEORGE T. MOSELEY: *Mr. Chairman*, I simply want to say in reference to the failure of examination in that case, that if our foresight were as good as our aftersight, we would be a very wise lot of people, medically and surgically. Apropos of Dr. Wilcox's case I would like to report one which occurred in my experience. A lady sent for me suffering very intense uterine cramps, with a history of having been operated on in another city between four and five months previously, for lacerated cervix. She had not menstruated after her operation, and being a married woman, I naturally suspected pregnancy, which so often occurs following operation for lacerated



cervix. I fancied I had a beginning miscarriage to deal with. The pains were paroxysmal, very intense, but there was no discharge from the uterus. Nothing gave her any relief. On examination, I found the uterus moderately enlarged, but with nothing like the enlargement of a four and a half months' pregnancy, and quite a decided mass on the left side of the uterus, which gave me the impression that there might be an extra-uterine pregnancy. On carefully questioning the woman, who was the wife of a clergyman, she gave a history of absolute abstinence from intercourse following her operation—she had not been well—and she told me there was absolutely no possibility of pregnancy. I then attempted to explore the interior of the uterus, and found I could not pass the smallest probe. The case was found to be one of stricture of the internal os, from adhesions at the time of the healing of the cervix, and the uterine cavity was full of retained menstrual fluid from the four menstrual periods which she had had, with escaping fluid into one tube. The tube on the opposite side seemed normal. I incised the cervix and gave exit to the retained fluid. That in the tube did not escape, and when I saw the patient last she still had a dilated tube on the left side, which, however, has given her no trouble since. It was an interesting case as showing the difficulties of snap-shop diagnoses without a careful examination of the conditions of the individual.

GEORGE R. CRITCHLOW: *Mr. Chairman*, the case reported by Dr. Wilcox illustrates one point which I think we have in our power in the line of diagnosis, and that is determining between inflammatory and non-inflammatory conditions of doubtful nature in the abdominal cavity. It has been asked why Dr. Wilcox did not examine the hymen first. I should like to ask another question: why he didn't examine the blood. The blood is of use in a great many cases in what it tells us, and it is decidedly useful in determining between inflammatory and non-inflammatory conditions in the abdominal cavity. I doubt whether Dr. Wilcox's case produced what would have been present in a large majority of cases of inflammatory conditions in the abdomen—leucocytosis. The blood which was forced out through the fimbriated extremity of the tubes was probably absolutely aseptic, and unless he had, which is questionable, a secondary pelvic peritonitis from that condition, he would have been able to exclude any inflammatory trouble, and then have looked for a mechanical cause. The only other thing that might have been in doubt would have been an extra-uterine pregnancy, and if there had been the hemorrhage of extra-uterine pregnancy, that could also have been told by the condition of the blood.

S. R. SNOW: It is always easier to stand aside afterward and ask why such and such a thing was not done. If an oculist were here perhaps he would like to ask Dr. Wilcox why he didn't examine the eyes or something of that kind. But it is pretty hard work when you have a case in hand to do everything and always be sure you are doing everything that should be foreseen in the case. I should take issue with Dr. Roberts in regard to the importance of not rupturing

the hymen. A case that occurred recently in our courts at Rochester shows this very clearly. A school teacher there was discharged from her position, having kept too frequent company with a young man. When the case was taken into court she submitted to the examination of two physicians, and the hymen showed positively, or what we must regard positively, that intercourse could not have taken place and left the condition present at the time of that examination. So strong evidence was this that the plaintiff asked for an examination, and this examination was permitted, and the plaintiff's physician was put upon the stand and swore that she believed that the defendant could not have had intercourse and at the same time have the hymen in the condition it was in at that time. I think a case like that shows the importance of leaving the hymen intact. In my experience I had a case brought to me similar to that of Dr. Wilcox, within the last two years—a girl about fourteen years of age, who had had the pains which a girl generally has when she commences being unwell. In this case the hymen had been examined before the case was brought to me, so it prevented me from making any mistake in that way. In fact they had tried to make an entrance into the uterus, but had been unsuccessful. I took the case, and it gave a history to the effect that when the child was six years old there had been some vaginal discharge, and they had used a corrosive injection which had set up an inflammation in the vagina, and the walls of the vagina had been so inflamed by the injection used that they had shut right together and occluded the vagina for its entire length, and it was with great difficulty that the vagina was opened again. It was opened, however, and the os dilated, and immediately came this backed-up flow of menstrual blood which had been there for some time. The case passed out of my hands into the care of the other physician, and he had so much difficulty in keeping the vagina open that it finally resulted in a hysterectomy because the vagina could not be kept intact.

Dr. Wilcox, will you close the discussion?

DEWITT G. WILCOX: When I was interne in a London hospital there was brought into the hospital one night an Irish woman who had been run over by a cab and broken her leg. In removing the shoe and stocking the filthy condition of both of them, as well as of the leg itself, suggested that the woman was not particularly well acquainted with the art of bathing. In fact, the condition was such that the patient's own attention was drawn to it, and looking at the leg, she said, "Oh, doctor, if I had known I was going to get hurt I would have dressed for it." (Laughter.) If I had known I was going to make this mistake I should have made the examination. I read that paper just to show you that I did not make the examination and that I did make the mistake in the diagnosis; and it emphasizes the fact that we have to be so very careful in every case, however plain it may appear to be otherwise. Yet I am inclined to think that a goodly number, I may say a majority, of surgeons similarly situated, with the conditions apparent in that case, would have assumed, with



a good degree of reason for doing so, that that patient did have or had had appendicitis. I am not in the habit of making a digital examination in young girls. I do it in every case with adult women, whether married or not, before venturing upon an operation of pelvic or abdominal incision. As Dr. Roberts and Dr. Snow say, there is that feeling among surgeons, and I think with some justice, and I do not feel at liberty in every case to insist upon making a digital examination, and it seemed hardly necessary in this case, because the condition seemed quite clear, that the appendix was at fault and that we ought to make the abdominal section. I made no mistake in making the abdominal section. I am inclined to think that possibly if I had discovered the exact condition, opened the hymen and released that blood, I am free to assume that that would have relieved the patient entirely, and that the abdominal fluid would have taken care of itself. It might, and again it might not. I might have had a peritonitis that would have been very serious in time, and I would scarcely have thought I had done sufficient simply to open the hymen and relieve the uterus and vagina of that accumulation of blood. So that the abdominal section really was necessary. But there was a mistake absolutely in the diagnosis, in assuming the case to be one of appendicitis. In answer to Dr. Garnsey's question, I don't know why the peritoneum did not absorb that fluid, unless it was on account of the quantity. The peritoneum will do a great amount of work, will take up fluid to quite an extent, and yet it may be so overburdened that it cannot go further. I doubt the point that Dr. Critchlow presents, of being able to diagnose that case with any degree of satisfaction by the examination of the blood only. I do not think that would have told us very decidedly, although I believe firmly in the use of the blood examination at that time.

E. A. SIMONDS: I simply want to say, Mr. Chairman, that I delivered a woman of a healthy child, where the pregnancy had occurred with an apparently non-perforate hymen. The opening of the hymen was so small that it would scarcely admit the entrance of a probe. I made a careful examination of the girl, who had been subject to spasms, and found what I believed to be the condition that Dr. Snow describes, of an obliterated vagina, soon after she was married. There was no vagina apparently. I was called to attend her in labor something like a year afterward. I incised the hymen and delivered the patient of a healthy child.

G. W. ROBERTS: *Mr. Chairman*, I wish to report another case of that sort in the Hahnemann Hospital, New York, about three years ago. I attended a woman who at full term had a hymen with an opening in it that would not admit a lead pencil. Now, the decision in the case quoted by Dr. Snow, if it was based upon the presence of a hymen which was intact, had no basis. It is no evidence. A woman can become pregnant with an opening in the hymen so small that it will not admit an ordinary pencil, and I have seen such cases.

S. R. SNOW: I do not deny that a woman can become pregnant with an imperforate, or small opening in the hymen, but that she

can have complete intercourse with a hymen of that kind, I do not believe is possible. The attorney for the plaintiff, in the case to which I alluded, asked me upon the stand if I believed the woman had had intercourse. I said no; and he asked me if I thought she could have had incomplete intercourse. I asked him to define "incomplete intercourse," and he couldn't do it. Consequently it let me out of answering his question.

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# REPORT

OF THE

BUREAU OF NEUROLOGY.

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## AN ANATOMICAL FACTOR IN MENTAL AND NERVOUS DISEASES.

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Ever since the creation of Adam the prepuce has been an appendage of man. The cry of the christian nations is now, and ever has been, against the sacrifice of this worthless piece of integument. They claim that the foreskin is a physiological adjunct to man and fulfills certain purposes in the human economy for which it was intended, and believe because God bequeathed it, it is a sacred, necessary and indispensable portion of man's anatomy, and are, therefore, very pronounced in their objections to its removal, rarely acceding, except in pathological conditions, when surgical interference is imperative and advised. It does not dawn upon them that conditions have changed in the human race since its advent; that things useful and necessary at that time have become worn out or replaced by more modern and improved ones. During the primeval days of man, before clothing was introduced, when the fig-leaf was not sufficient to ward off the bites of venemous insects or the scratches of thistles or briars, it was then that the prepuce had its province (if at all) as a protection to the glans from irritation and injury; but with the strides of civilization and the adoption of suitable clothing and



hygienic measures, the foreskin has long since outlived its usefulness and merely remains an exile, a relic of antiquity which is usually over-developed and disproportionate to the glans which it ensconces. Like the vermiform appendix, its only function seems to be to make trouble for man, and I believe at least fifty per cent. suffer, either directly or indirectly, from its presence.

The introduction of circumcision is clouded in obscurity and many are the theories advanced for its origin. Historians differ as to the date of its beginning; some claim it was introduced 6,000 years before Christ. The records of Herodotus and Diodorus verify the antiquity of the rite, for during the exploration of the Egyptian tombs mummies were discovered bearing marks of the operation. Donnelley claims that it dates back to the first days of the Phoenicians, Egyptians and Cushites, and believes it was "invented" 10,000 years ago. He says, in his book, "Atlantis": "It was probably resorted to in Atlantean days and imposed as a religious duty to arrest one of the most dreadful scourges of the human race—a scourge which continued to decimate the people of America, arrested their growth and paralyzed their civilization." He undoubtedly refers to syphilis, for he further says: "The colonies that went over to Europe carried the practice but not the disease out of which it originated with them (the Atlanteans having stamped it out). And it was not until Columbus reopened communication with the infected people of the West Indian Islands that the scourge crossed the Atlantic and turned Europe, as one has expressed it, 'into a charnal house.'"

The institution of circumcision, as practiced by the Jews of to-day, is directly traceable to Abraham. The Bible says God made a covenant with Abraham and required as a sign of their compact that he, Abraham, should be circumcised; also his sons, his male slaves and their seed forever. (See Genesis, Ch. XVII.) Since that time it has been held in strict obedience by the Hebrews as a religious ordinance.

At different periods of the world's history circumcision was employed for other purposes than that of religion. Some tribes used it to brand their slaves; others claimed it was an evidence of manhood and performed it on their adolescent sons; some considered it an act of national or political distinction, while the warriors of some barbaric tribes scalped the penis to exhibit as trophies of their valor.

It was not employed as an hygienic measure until 600 years before Christ, when the Egyptians first recognized its sanitary import (Remondino.) Donnelley says, however, that it was used hygienically from the first, and cites the case of the Atlantean king, (the Greek God), Ouranos, who, in time of a plague, compelled his entire army, together with the armies of his allies, to undergo the operation. (This, in all probability, is a legendary tale.) It is a well-known fact that particles of foreign matter in the nostrils and respiratory tract will produce irritation, inflammation and give rise to reflex acts, such

as coughing and sneezing, the cause for which is easily found. Likewise is it similar with the prepuce: The imprisoned smegma, aided by heat and moisture and the constriction about the glans, produce irritation, followed by inflammation, pain and swelling, and sometimes by a purulent discharge; this condition is just as readily recognized as the former on account of its local symptoms, but when the irritation is so slight that attention is not called to that organ, many parents and physicians are at a loss to account for the numerous reflex neuroses which it often produces, and in such cases protracted suffering ensues before the seat of trouble is finally located. Why, then, should not circumcision be universally employed as a prophylaxis against such conditions? Such a proposition would hardly be entertained or countenanced for a moment; it would be received with ridicule and laughter. The idea of Christian nations aping the despised Jews would be considered preposterous and intolerable. Notwithstanding, however, the fact that the Hebrews have been scoffed at, insulted, ridiculed, persecuted, and even massacred, they have stuck to their religious beliefs with bulldog tenacity, and stand together to-day stronger than ever before, freer from disease than their Christian neighbors, and the inheritors of a greater longevity than any other race. Well and profitably, as a medical measure, might we emulate their example.

What, then, are the benefits that can be offered to suffering humanity through circumcision? In setting forth its advantages, I naturally turn to the Hebrew as the unit of comparison. The great and incontrovertible argument in its favor is readily shown by the records of vital statistics in all countries, the Jew having by far the largest balance on the ledger of life. It is also a matter of interest and of fact that the Hebrews are not so prone to sickness and show much more resistance to epidemic and contagious disease. The lessened mortality, especially of their children, stands in marked contrast to those of other nationalities living near them. Mayer reports he found in Furth that children from one to five years of age died in the proportion of ten per cent. among the Jewish and fourteen per cent. among the Christian population. Lombrose claims that of every 1,000 Jewish born, 217 die before the age of seven, while 453 Christians, double the number, die within the same period. Neufille estimates that the average length of life of the Hebrew is forty-six years, nine months, as against thirty-six years and eleven months of the Christian.

Richardson, in his "Diseases of Modern Life," says the Hebrews escaped the great epidemics more readily than the other races with whom they lived, and claims the mortality from cholera amongst them was so small that the very fact of its occurrence was disputed.

Frederick L. Hoffman, in his articles, "The Jew as a Life Risk," published in *The Spectator*, a journal devoted to life insurance interests, in November, 1895, gives some very interesting and valuable information concerning the longevity of the Jews in the Hebrew ghettos in New York City. He gives the death rate per 100,000 on the population of the Seventh, Tenth and Thirteenth wards as follows:



| CAUSE OF DEATH. | Total. | U. S. | Ireland. | Germany. | Russian and Polish Jews. |
|---|---|---|---|---|---|
| Diseases of urinary system.. | 137.40 | 121.42 | 350.50 | 129.02 | 45.03 |
| Scarlet fever ..... | 22.38 | 31.95 | 20.42 | 8.80 | 28.35 |
| Typhoid fever ..... | 12.43 | 12.78 | 6.81 | 20.53 | 10.01 |
| Diphtheria ..... | 79.58 | 255.62 | 51.04 | 67.44 | 60.04 |
| Diarrhœal fever ..... | 293.45 | 683.79 | 217.78 | 225.78 | 251.83 |
| Consumption ..... | 328.89 | 268.40 | 752.03 | 372.39 | 106.74 |
| Pneumonia ..... | 381.11 | 498.47 | 704.39 | 284.42 | 220.14 |
| Diseases of liver..... | 25.49 | 12.78 | 71.46 | 32.25 | 5.00 |
| Diseases of nervous system. | 192.11 | 364.26 | 268.83 | 134.38 | 115.07 |

A glance at this table shows the smallest general death rate to be among the Jews and proves that the Hebrew has the greatest immunity from consumption and pneumonia, the dreaded diseases which are responsible for the greatest proportion of fatality among the American population.

To show death rates in same districts with distinctions of certain groups of ages and nativity, I quote again one of Mr. Hoffmann's tables:

| AGES. | Total. | U. S. | Ireland. | Germany. | Russian and Polish Jews |
|---|---|---|---|---|---|
| Total ..... | 26.25 | 45.78 | 36.04 | 22.14 | 16.71 |
| Under 15 years..... | 41.28 | 62.25 | 40.71 | 30.38 | 32.31 |
| 15 to 25 years..... | 7.55 | 9.43 | 15.15 | 7.14 | 2.53 |
| 25 to 65 years..... | 21.64 | 25.92 | 39.51 | 21.20 | 7.99 |
| 65 years and over.... | 104.72 | 105.96 | 120.92 | 88.51 | 84.51 |

As most applications for insurance are made between the ages of twenty-five and sixty-five years, the Jew stands, according to these figures, as the best of risks.

The majority of intelligent people who have looked into the matter and have become acquainted with the fact that a Hebrew is longer-lived, suffers less from disease and has a greater resistance for it, will not give circumcision the credit of having anything to do with the greater endurance of the Jewish race. They claim the temperate life of the Jew, the restriction of certain kinds of food and the careful attention to sanitary conditions accounts for the tenacity of life shown by the Jews, and yet they will not count circumcision as a factor among them.

Among the better classes these arguments might stand unassailed for years to come because it would be well nigh impossible to secure necessary data; these statistics, however, were not taken from among them, but rather from the poorest classes of aliens, handicapped by the environment of another climate, herded together in tenements, where the living room answers the purpose of parlor, workshop and bedroom; where the sanitary conditions are foul and where small opportunity, on account of their poverty, can be given for the selection of healthful foods. The majority of these Russian, German and Polish Jews earn their livelihood as tailors and work bent over indefatigably, in the sweat shops of the metropolis for twelve or sixteen hours each day, in a dark and vitiated atmosphere, condi-

tions which would exterminate any other race through tuberculosis, and yet they are comparatively free from it.

The records of the New York State hospitals show the commonest form of insanity found among the male Jewish inmates to be general paresis, with overwork and worry and sexual excesses as the predominating exciting causes. This, then, although the Jews may be less addicted to alcoholic intemperance than other races, refutes the common belief that he is not intemperate. His fatiguing hours of work and excessive indulgence in venery prove him to be no less abstemious than those of other nationalities.

It frequently happens in other races than the Hebrew that children are born without a prepuce, thus exploding the theory that the foreskin is a necessary attribute to normal and healthy man, for we cannot call these children deformed.

A question often asked is: Why are not all Jewish males born without a prepuce? It is true that only a small percentage of children are born with the glans exposed, but 95% of them are found among the Hebrews, showing conclusively that acquired characteristics are transmitted, and it is reasonable to suppose its frequency will increase as time goes on. The fact that the male alone is circumcised would not lead us to expect very pronounced results, as the female and heredity exert the greatest influence in the moulding of the offspring. Dr. Bauer, who operated 3,400 Jewish boys, found the prepuce absent in 3½% of cases. Cohen, with 10,000 circumcisions, found prepuces wanting in 500, partially developed in 300, and slightly developed in 2,200.

Dr. George Lockwood, of New York, has shown that acquired characteristics can be transmitted. White mice were selected for the experiment because they breed once a month. He bred them for thirty-six generations, destroyed the weak ones, and selected a stronger pair than the original ones. These he allowed to breed and clipped the tails of their young. In the seventh generation he discovered some tailless mice and finally obtained a tailless breed.

Let us consider some of the diseases which accompany the prepuce in its phimotic state. Probably the most frequent is difficult urination, which in its turn, is likely to be followed by inflammation, balanitis, cystitis, by hydrocele and various other ailments. Dr. Schmid reports he found phimosis to exist in 10 out of 100 boys who had hydrocele; which he claims was due to the straining exerted to evacuate the bladder. Dr. Friedbergh, in this connection, is of the opinion that phimosis leads to abdominal rupture, and Willard reports cases of goitre and hernia from such a cause. Bryant cites thirty-one cases of inguinal hernia; five double inguinal and a number of umbilical hernia observed by him in fifty consecutive cases of congenital phimosis. Nocturnal enuresis is a frequent accompaniment of both retractible and non-retractible foreskins, produced by the irritations from sebaceous secretions and preputial adhesions. I have had a number of such cases, which, after operation, quickly and permanently subsided. Cancer of the penis is often found with



phimosis. Dr. Hay reports nine cases out of twelve who had cancer associated with it; Roux and Collier found it to exist in the same proportion. It is, therefore, not improbable that phimosis is directly responsible for the development of cancer; it, however, to say the least, promotes its growth by the continuous irritation it produces. Travers claims cancer of the penis has never been observed among the Hebrews. The sexual sphere is also disturbed by phimosis. Coition is often painful and often impossible, and, in numerous instances, impregnation has failed to occur on account of the obstruction to the flow of semen. Phimosis promotes the infection of syphilis, on account of the tissues being easily torn during coitus and it naturally follows that people adorned with prepuces, whether they be phimosed or not, are more prone to venereal diseases than in those where they are absent.

The gravest results of phimosis manifest themselves through nervous disturbances, and range all the way from stupidity, perversion of temperament, nervousness, disorders of digestion, chorea and fright to hypochondriasis, epilepsy, paralysis and insanity.

In this connection I wish to briefly report a few cases where the nervous system was involved:

Case No. 1. Child, eight years of age; family history good; up to five years of age he was apparently as bright as other boys and had a kind and cheerful disposition. From that time on his temperament slowly changed and he became irritable and cross and hard to manage. He was sent to school, but took such little interest in his books and surroundings that he soon dropped behind the boys of his own age. When his father brought him to see me, he was pale and anæmic and presented a dull and stupid appearance. He had been wetting the bed for two weeks previous and was afraid to play with his companions. Examination revealed a long and tight, but retractible foreskin. He was operated upon and began to improve immediately; the nocturnal enuresis soon disappeared and in six months' time he had caught up in his studies to boys of his own age, and became the brightest boy in the family and one of the very brightest in his class.

Case No. 2. Four years ago, the head attendant in the epileptic ward of the Middletown State Hospital asked me to see his boy, four years of age, who had had three epileptic convulsions which he believed were caused by a tight foreskin. The prepuce I found to be in a state of complete phimosis, having only a pin-sized opening for the escape of urine, which pained him so at times that he cried out. I operated and found the mucous membrane bound down by adhesions in over two-thirds of its circumference. The cure was complete and permanent; the child never had another convulsion and is strong and hearty to-day.

Case No. 3. Young man, aged twenty-three. German parentage and excellent family history; occupation, barber; habits, exemplary; denied masturbation. He came to me two years ago last November in a very depressed state of mind; said he had been under an old-

school physician's care for stomach trouble for nine months without improvement and now thought he never would be well again. Said he was so nervous that he was unable to rest well at night; his sleep being greatly disturbed by his great restlessness. He awakened between four and five every morning with a severe frontal headache which lasted most of the day, and would be unable to fall asleep again. He was anæmic in appearance, had lost a great deal in weight and complained of great distress in his stomach after meals. At frequent intervals during the day, while shaving customers in his employer's shop, would suddenly become seized with such tremor and jerking in his wrist that he could not go on. These nervous spells were accompanied with trembling in all his limbs and a sudden weakness of the body and lightning-like alternating currents of heat and cold coursing up his legs and spine. Physical examination showed him to be only fairly well nourished; prepuce covered the glans and was retracted without difficulty. I put him upon a carefully selected diet, prescribed plenty of outdoor exercise and the indicated remedy from time to time. He did not improve any in the first six weeks except that his stomach became less intolerant. His depression increased, he became fearful he would lose his position and was fast becoming a hypochondriac from worry. I suspected masturbation, and, notwithstanding his continued pretestations of innocence, decided to circumcise him, if only for the moral effect. He began to pick up right away. Two weeks after the operation he showed decided signs of improvement. He went four days in that week without being obliged to stop his work and began to rest easier at night. Two months later his nervous spells had about left him, having only one on an average of once a week and he was able to sleep soundly until six a. m. With this marked improvement his spirits began to revive and he continued steadily to improve until May, when I discharged him recovered.

I have never seen cases of paralysis due to phimosis, although numerous cases have been reported. Dr. Sayre, of New York, observed in a number of cases paralysis of the lower extremities, associated with phimosis and priapism which led him to write a paper for the American Medical Association on "Partial Paralysis from Reflex Irritation Caused by Congenital Phimosis and Adherent Prepuce."

These are not all the ailments traceable to the prepuce, but they will suffice to show the baleful effects due to its presence. The object of this paper is to bring out, as fully as possible, the relation of the prepuce to mental disease; but before doing so, I wish to call attention to the normal or retractible prepuce—the prepuce which is generally considered necessary and without which it is believed by many humanity suffers much misery through masturbation and nervous irritation.

I have never been able to understand upon what grounds the opponents of circumcision base their belief that the prepuce tends to prevent, rather than to increase, the tendency to onanism and



nervous disturbances. Such claims are made, however, without the advancement of reliable or tangible proof.

After circumcision the glands and tissue adjoining become hardened and somewhat indurated, thereby deadening its sensibility to such a degree that the friction produced by clothing is scarcely ever recognized; while, as has been shown, the irritation from the secretions and constrictions about the glans from the prepuce causes numerous reflex nervous conditions.

I do not mean to convey the idea that circumcision produces immunity from masturbation in those circumcised, although it decreases the tendency thereto; for the causes of onanism, the evil instruction of depraved companions, the inheritance of a weak and neurotic constitution, consanguineous marriages and the reading of vulgar and salacious literature, grasp their victims regardless of race, religious creed or social standing. One of the not infrequent causes of masturbation, *which the Jews escape*, is a tight or elongated foreskin. In the case of the former, a sense of discomfort and irritation is felt, while in the latter the loose folds rubbing against glans produce a more or less sexual erythrism; these two conditions call the person's attention to that organ, the habit, in numerous instances resulting. It is argued that if the prepuce were washed out every day and the penis kept in a state of cleanliness circumcision would not be necessary, as the irritation which causes masturbation would be removed. This argument is not without error because the too frequent handling of the genitals and rubbing of the sensitive mucous membrane while cleaning produces sexual excitement which is likely to be, and has been, followed by masturbation. This rule of enforced cleanliness is not received with favor among the young and is a failure in nine cases out of ten, on account of the inconvenience and discomfort associated with it. Besides being a cause of masturbation, epilepsy and various nervous disturbances, and acting as a receptacle and culture for the germs of gonorrhœa, syphilis and cancer, the *normal or natural prepuce* is often the seat of œdema, balanoposthitis, gonorrhœal balanoposthitis and diphtheritic balanoposthitis, herpes progenitalis and præputialis, elephantiasis præputii, etc., conditions which could not exist in the absence of the foreskin.

It is undoubtedly true that a relationship exists between the prepuce and insanity, and although it may occur only in a small percentage of cases, *its existence may not be denied.*

The prepuce has been known to have caused masturbation, and masturbation caused insanity. It is, therefore, necessary to associate the two to determine their relation to each other. In my paper on onanism and its relation to insanity (*Hahnemannian Monthly*, May, 1899), I reported that onanism was the cause of insanity in 6% of the cases admitted to the Middletown State Homœopathic Hospital, and investigation showed, in nearly every case, that the prepuce was present. Since then I have made inquiries, from time to time, from those patients who were able to answer

intelligently as to the causes of this habit, and learned, in a few cases, that the foreskin was the exciting cause. One told me that the itching and burning from underneath the prepuce started him in this practice, while another, of an inquisitive and investigating turn of mind, said he drew back the prepuce to find how things looked underneath it, and rapidly succumbed to the habit. There are, no doubt, many other instances like these on record which can not be obtained from this class of patients, who, as a rule, have no regard for the truth and are ashamed to speak it. Even in those insane from other causes the prepuce exerts a baleful influence on the course of the disease. While assistant physician at the Middletown State Hospital, I circumcised over 100 cases, irrespective of the form of insanity, ranging in age from sixteen to eighty years. These cases I watched carefully for over two years and found that in acute cases recovery, as a rule, was greatly augmented. In the chronic insane, although no recoveries ensued, the outbreaks and duration of maniacal excitement were much modified and masturbation evidenced to a far less degree.

An interesting case of melancholia, age thirty-eight, was admitted to the Middletown State Hospital in May, 1875; No. of attack first; duration three years; lawyer by occupation; temperate in the use of alcoholic stimulants; admitted excessive indulgence in masturbation and venery. He suffered a great deal from depressing delusions, having the common one of committing the unpardonable sin. He remained but a few days, when his friends came and took him out. Three years afterward he was readmitted, having spent the interim in hospitals in Rhode Island and Connecticut. In addition to his previous delusions he had a number of an erotic type and was greatly annoyed by frequent seminal emissions which greatly weakened him. Three months after his admission, by his own request, he was operated upon for partial phymosis. Immediately after the operation he began to improve and was discharged recovered ten months later, after having been insane a period of over thirteen years.

A no less remarkable case is on record at the same institution. A boy, an imbecile, eleven years of age, suffering with mania and epilepsy was admitted in January, 1889. He had a history of periods of excitement, at frequent intervals, for five years previous to admission, when he would become ugly, destructive, and violent. Two years after these outbreaks he developed epilepsy and has had a convulsion on an average of once a week ever since. In *April* he was circumcised. Shortly afterwards the fits became more infrequent and his mind began slowly to clear up. The improvement continued gradually for two years, when he was taken out and put in the Rome Custodial Asylum. He presented no especial symptoms at that time save those of mental enfeeblement, the mania and epilepsy having left him. He was afterwards discharged from the Custodial Asylum and taken home, where he has been ever since. A letter from his folks two years ago stated that he had never had



a return of the convulsions or outbreaks of excitement and was enjoying as good health as he did previous to the attack.

When we note the good effects of this operation upon the insane, we cannot help but believe, had circumcision been performed early in life, the predisposition to insanity in some of the cases might have been removed or at least the severity of the symptoms modified.

Through the courtesy of the superintendents of the New York State Hospitals for the Insane, in 1900, I was able to ascertain the number of Hebrews undergoing treatment. Out of the 22,658 inmates, 790 were found to be Jews. Taking 7,000,000 as the population of New York State and 600,000 the *Jewish World's* estimate of the number of Hebrews in Greater New York, claimed to be a conservative and minimum estimate, we find that one in every 759 Hebrews go insane, while one out of 292 of other creeds have mental disease. This ratio is not absolutely correct and errs on the side of the Non-Jew, because only the Hebrew population of New York City is taken as a basis for comparison. When we add to this the fact that 98% of the Jewish inmates of our State institutions come from the poorer sections of New York City, a vast majority of these from tenement districts, while those of other races are received from different parts of the state and various walks of life, the contrast becomes most marked and clearly shows the greater resistance of the Hebrews to mental disease.

Circumcision, as performed by many Jewish Mohels (operators), needs many radical changes. The operation, to say the least, is barbarous and unscientific, little attention being paid to aseptic or antiseptic methods. I have seen operations where the operator neither washed his hands nor cleaned his nails or the penis to be operated upon. The method employed among them was to draw the foreskin out until the tissues became tense, and, without clamping or marking out the portion to be removed, cut with a sweep of the knife the already extended prepuce. Then with their thumb nails, which had been allowed to grow long and cut to a sharp point, they lift up the mucous membrane and either roll or tear it until it is brought back of the corona. This is a very painful procedure, as the only anæsthetic the child receives is a rag filled with sugar water, made in the form of a nipple, to suck on. The operation was completed by an antiseptic dressing. If hemorrhage ensues, it is supposed to be controlled by suction from the operator's mouth through a hollow glass tube made to fit over the penis. We occasionally hear of serious complications and sometimes death resulting from these operations. While taking a course in the Broome St. Dispensary, New York City, in 1893, I learned of the death of a Hebrew child from having the glans severed. A prominent Hebrew in New York City told me one of his sons nearly died from post-operative hemorrhage; since then he has been a strong opponent to the Jewish rite. The *Medical Record* (Oct., 1900,) cites a case of mortality, the result of ignorance of the Mohel. Many similar cases I have no doubt exist which do not come under the eyes of reporters. The

attention of the state should be called to the criminal way in which some of the Jewish operators perform circumcision and proper laws enacted governing its performance. It is just as necessary that the lives of innocent babes be protected by legislation as women from the fatal influences of unskilled midwives. The feeling among a few eminent rabbis and a number of intelligent Hebrews is against the operation of circumcision. They say it, as practiced by the average Mohel, is too bloody and painful and too often followed by serious results. I know of a number of Jewish families who refused to allow their sons to be circumcised on account of the foregoing facts and am told this sentiment is increasing in the race. It is a pity that an integral factor of the greatest law of the universe—self-preservation—is beginning to retrograde, and yet with the expression of such a growing sentiment a decrease in the Abrahamitic rite must result. Even now proselytes are admitted into the Jewish church without undergoing the rite of circumcision. (Report Central Conference Rabbis, 1892.) I trust before any serious opposition is raised to circumcision, the Hebrew church will assert itself and sanction an operation performed only by licensed physicians. The Israelites, through a Divine Command, stumbled upon one of the greatest boons humanity has ever known, and should they now relegate it to the limbo of lost and unregretted things, they would again barter a priceless heritage—health and longevity—for a debatable mess of red pottage. Should proselytism swell their ranks to any great extent, there is danger that the resistance to disease and death shown by them will decrease in no small proportion.

I do not claim circumcision is a panacea for all ills, although its benefits are manifold. It is, however, a trivial and harmless operation and should be more universally employed by physicians than it is to-day.

Taking all points into consideration, I firmly believe circumcision exerts the strongest influence for hardiness in the Jewish race. If it be not so, can some one satisfactorily eliminate it as a factor and gainsay the fact that if any other race had practiced circumcision from the beginning as religiously as the Hebrew, it would not enjoy the same benefits to-day?

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## DISCUSSION.

P. W. NEEFUS: Dr. Powelson's paper is open for general discussion. I won't take up any time. I know it is a subject we all think of a great deal. I know in my own practice if I get a nervous child, boy or girl, they do not leave my office, or I don't leave the house, until I have looked over their genital organs.

C. E. LANE: I believe that after circumcision it is as necessary to keep track of the foreskin and notice whether there are adhesions of the glans as it is to do the circumcision. Several years ago I was



called in to see a child in a hurry, whom they told me, had been in convulsions for four hours. I asked the mother if the foreskin was all right, and she told me that an old-school physician had assured her that it was, but I insisted on an examination. I found a short foreskin, easily retracted, plenty of room, but adhesions of the approximal edge of the glans to the foreskin. I broke up the adhesions, and found considerable smegma. I directed the mother to apply powder or vaseline and keep it clean until the rawness had disappeared. There were no more convulsions at that time. Some six months after that I was called to see the same child again, in short convulsion. The mother told me that the glans were all right, that she had allowed no adhesions there at all. I examined the glans again and found about an eighth of an inch of adhesion. I broke up the adhesion, directed the mother again how to prevent their further occurrence, and supposed it was all right. A year after that I was called to see the same child again. It had another convulsion, a short one. When I arrived I examined the foreskin again and found an adhesion covering a space not larger than a small pin-head. I again broke up the adhesion and directed the mother about keeping it all right. It has now been something over four years and there have been no more convulsions. We find adhesions of the foreskin even at birth many times needing circumcision, and even in those with short foreskin sometimes. I believe it is as essential to watch the foreskin of a female as of the male, and where there is a long foreskin, to circumcize it and keep the clitoris free. Peevish girls and girls that have convulsions recover from those troubles after keeping the clitoris free the same as boys do after keeping the glans penis free. An old lady came to me with her lady physician some five or six years ago, somewhere between sixty-five and seventy years of age, saying that she had an increasing delusion that all men were watching her and wanting intercourse with her—and there was nothing about her general condition that would warrant anything of the kind—her general physical condition was good, with that exception. On examining the vulva I found that the clitoris was completely covered with adhesions of the foreskin and on breaking up the adhesions I found a piece of smegma as large as a pea, quarter of an inch in diameter. I removed that, and keeping the foreskin broken up, she recovered completely from this delusion and has had none of it since.

H. C. ALLEN: *Mr. Chairman*, This subject has been somewhat dilated upon in the last decade by our surgeons—we have one in Chicago, Dr. Pratt, who goes a little further than the paper this morning—on the same lines; and I want to call your attention to the fact that in the foot note to § 7, Hahnemann calls our attention to this, that we should remove the exciting cause of disease whatever it may be and wherever we may find it. Also about eighty-five years ago Hahnemann called our attention to the fact that we very rarely have a mental disease, *per se*, that almost all our mental diseases depend first upon a physical disease, that if we cure this physical

ailment we relieve the patient of the mental disturbance, or they rarely occur; and he goes a little further and says also that nearly all these physical troubles from which mental diseases arise are traced directly or indirectly to some miasmatic difficulties—psora syphilis, or tuberculosis—or something else. Hence, when we are advocating the removal of the foreskin or the dilatation of the sphincter or the treatment of some other morbid derangement that is keeping the physical body in a disturbance, we are removing the cause of mental disease and we should look to it that that be done, as followers of Hahnemann we should always remove every cause of physical disturbance that is possible. Hahnemann even goes so far as to say "open the imperforate hymen".

J. L. MOFFAT: I have in mind a young girl who suffered for years with neurasthenia—broke down from overstudy—which has developed a hysteroid condition and finally hallucinations and morbid fears. Freeing the clitoris failed to cure—the operation was followed by erections—and so has suggestive therapeutics. After long effort she has been separated from her mother and will have a chance to recover her health. The mother had become morbidly anxious and watchful, was continually asking how she felt and telling her not to do things that would not really harm her.

P. W. NEEFUS: Dr. Powelson, have you anything to say?

A. P. POWELSON: I think not, Mr. Chairman.

P. W. NEEFUS: If you will allow me one word. It is my practice in all these cases that are operated on to keep the parts bathed with carbonated vaseline. I use no water, use nothing to wash it with except vaseline after the adhesions are broken all the way through, until it is thoroughly healed; then give it a good cleaning and get the grease out. Dr. Moffat's remarks are in keeping with the paper that is to follow, "According to Hudson," by Dr. Greenleaf, who will now present his paper.

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## ACCORDING TO HUDSON.

JOHN T. GREENLEAF, M. D.,
OWEGO.

A paper written for a general medical society by any specialist should conform to two rules, at least. First, it should deal with a matter that will be of use to the general practitioner, and second, it should be so written as to impress the busy mind of the man who has to meet all kinds and phases of disease single-handed.

The writer of this paper will keep these two points in mind in offering for the consideration of this Society a brief resumé of the



"working hypothesis" of Dr. Hudson regarding hypnotism, both as to the use of that strange influence, the real conditions controlling its employment and the actual relations between the operator and the patient, under the spell of its peculiar state, condition or domination.

From time immemorial down to the present day in the hands of all classes, under the control and practice of all ages, employed alike by the savant and the charlatan, by the philanthropist and the murderer, by the physician and the libertine, this peculiar influence of one mind over another has been recognized and studied, under many names, yet the same in principle, used for many purposes, yet the same in general results, it has been a problem, an enigma, a matter of guess-work in all ages.

Its phenomena are familiar to all scientific men and the writer refrains from any delineation of them to this gathering of intelligent physicians. In the progress of its evolution in the scientific world, many keen minds have exhausted themselves in an effort for its solution. Mesmer, Charsot, Meyer, Bernheim, DuPrel, Brown-Sequard and hosts of others are only a few of the stars in this constellation of searchers after truth.

Very marked divisions have occurred in the ranks of students and philosophers about this condition of mind, or influence upon mind. The Paris school holds one thing, the Nancy school another, and so on *ad infinitum*.

The consensus of advanced thought, founded on accurate investigation, for the last quarter of a century seems to have set forth the fact that it is an abnormal state of the mind that exists, or may exist in every one, to a greater or less degree; that some can employ its power with great facility on certain subjects, and not at all on others; that many can obtain partial results only, and that many cannot employ its power, nor can all be brought under its dominion.

With this very much confused statement of its status, with its history as a weird and mystic power, with the disappointing and often disgusting confessions of many adepts in its use, is it to be wondered that it is held in bad repute, and relegated to the profitless realm of the supernatural by the thinking, active and successful practitioner?

For the purposes of this paper it would not be well to advance any of the many theories as to the methods used in its practice and the actual condition of the minds of both the operator and the patient in its employment. Suffice it to say that none of these theories apply satisfactorily to every phase of this peculiar psychic phenomenon, yet in many of them there is much that is true and much that is correspondingly useful.

Gathering up all the good and the markedly useful in what has been written before by the hosts of students of psychology, Dr. Thompson Jay Hudson, of Washington, D. C., has given us a theory which, as far as it has been applied by the writer of this paper, seems to solve all the problems of hypnotism and its correlated phenomena,

not excepting telepathy, so called spiritualistic manifestations, trance healing, christian science, etc., etc.

The initial and fundamental statement of the doctor is that the human mind exists in a quality; that there are two minds; each of which has its special characteristics and properties.

"Briefly, the objective mind—for want of a better term, manifests "itself in taking cognizance of the objective world. Its media of "observation are the five special senses. It is man's guide in the "struggle with his material surroundings. It is the outgrowth of "his physical needs. Its highest function is that of reasoning."

"The subjective mind—also a term used for want of a better one— "takes cognizance of its environment by means independent of the "physical senses. It perceives by intuition. It is the seat of the "emotions and the store house of memory. Its highest functions "are performed when the objective senses are in abeyance. It is the "intelligence which makes itself manifest in a hypnotic subject, when "in a state of somnambulism."

Possibly it is not too much to say that the "objective mind" is merely the function of the physical brain, the "subjective mind" when reduced to the last analysis, is the soul.

It is also safe to affirm that the "objective mind"—man in his normal condition—is not controllable by the suggestions of another, against reason, positive knowledge, or the evidence of his senses.

On the other hand the subjective mind—or man in a state where the objective mind is in check—the hypnotic state—is constantly amenable to the power of suggestion that is to say, that the subjective mind accepts, without hesitation or doubt, every statement made to it, no matter how absurd, incongruous or contrary to the objective experience of the individual.

The man whose objective mind is held in check for the time being, is so thoroughly under the control of the dominating mind that he may be made to feel, see, hear, smell or taste anything in obedience to suggestion. He may be raised to the highest degree of mental or physical exaltation or he may be plunged into the lethargic or cataleptic state by the same power.

It may not be asking too much that the foregoing statement and definition be accepted as true and be exploited as a working hypothesis. If the established laws of hypnotism, the discoveries in psychical research and the repeated observations in the employment of these laws can be explained by this tentative rule, and if its power can be utilized for definite and constant results in every field of the domain of hypnotism and its allied phenomena in accordance with its dictates of this hypothesis, it is safe to say that it is no longer a hypothesis, but is the foundation law of this branch of psychology.

Proceeding then, to explain some of the practices in this domain by this hypothesis, it may be stated that the first and most important step in the use of hypnotism is to get the subject to restrain, to hold in abeyance, to render inert the objective mind. Many devices have been adopted, but the fixing of the eyes upon some one small, bright



object held within the range of vision seems to be the most approved style of procedure.

This fixing of the vision concentrates the mind and thought on this one thing, but as it is held too close to the eyes for the accomplishment of clear vision, the brain is temporarily left a blank—if that phrase can be admitted—because of its concentration on a futile task, and thus the trance state is easily reached.

While he recommends this procedure, Bernheim is positive in his directions for the operator in hypnotism to obtain the same end by slow and gentle speech, by a brief lecture on the point of relaxing the mind, for the initiating an effort on the part of the patient to be passive, and to render the objective mind inert and ineffectual for the time being.

This is the process of hypnotizing without the trance. Both processes aim at and accomplish the same thing.

Having removed the domination and control of the objective mind by any method whatever, the subjective mind is found open to suggestion and the impulse—for good or evil—may be planted at once.

This explains one more puzzle of the psychologist, namely: the fact that suggestions may be planted very effectually without carrying the patient on as far as the trance, and it makes the use of suggestion much more available, because the average patient recoils from being put into the unconscious or trance state.

A corollary to this proposition, which is most important to the physician in every-day practice, is that anything which tends to so impress the patient that he will lay aside his opposition to the operator and try to hold the objective mind in abeyance is just so much of a make-weight in the direction of obtaining a cure in nervous cases, just so much of an adjunct to the properly chosen remedy.

It goes without saying that many a good man has been chagrined beyond measure to know that another man—very likely his inferior in attainment and skill—has succeeded where he, the first man has failed, and that, too, with the same medication in a given case, simply because the one enjoyed the confidence of the patient and the other one had lost it.

Confidence—so-called—is not a matter of mystery. It depends upon and is obtained through the readiness with which the objective mind, with its prejudices, its *quasi* reasoning power and its unaccountable and irresponsible likes and dislikes, can be removed to a certain point from which it no longer dominates the subjective mind.

Everything that can be of use in so gaining control of the subjective mind in a given case is to be sought after, be it moral character, fine clothing, a winning manner, a sympathetic examination of the case, a tactful setting forth of the physical faults of the sufferer, the influence of powerful friends, a well-known reputation, an office full of books and appliances, anything, everything.

If a digression may be pardoned right here, it may be asserted that the triumphs of the fashionable cult known as Christian Science, may be explained and accounted for on this very basis. It would

not seem rational in the light of her course before the public to accord to the apostle of this popular fad, the knowledge and judgment to have selected the religious faculty of the human mind and heart as the best foundation for her partial imposture, yet her native shrewdness forbade her to enlighten her followers, or to abandon the certainty of the result when she had once fallen upon it.

Anyway, the fact remains that the operators in this cult do trade upon and build up by just that faculty. The attention of the weak minds of the nervous and the hysterical on the one hand, or the cupidity of the unscrupulous and the disreputable on the other, is enlisted by this *quasi* religious mysticism, of the influence of mind over matter, the moral (or immoral) nature is attracted by the seeming great discovery that mind can control matter, until the objective mind of the sufferer is held in abeyance and the process of hypnotism without the trance is accomplished.

The rest is easy, the patient who has made no effort toward health or sanitary living for years is induced by the repeatedly planted suggestion of the dominant mind, to use the power and strength he or she has in reserve and the so-called cure commenced.

One other great truth is also involved, the patient is encouraged to undertake the same procedure for another, thus fixing his or her own attachment to the planted suggestion and emphasizing the fact of the universality of the hypnotic power.

The whole system is simply the use of hypnotism. In so far as the devotees of this fallacy engage to help the nervous and the hysterical cases that are curable by suggestion alone, just so far they succeed, no farther.

Hypnotism is not a panacea. It will not reach organic disease, either in scientific hands or when employed by the charlatans above mentioned.

Query for the honest and thoughtful man: Shall I forego the manifest benefit of suggestion in proper cases for its use, because my ignorant and well-meaning neighbor promises too much for it, or because the tricksters generally are using it?

Returning then to the original theme, it is proper to add that any objective mind may suggest to any subjective mind. The person operated upon may suggest to himself or herself. Even though, either by his own desire, or by any of the devices of the trained psychic, he may, for the time being, abrogate the influence of his own objective mind in part, he may be fixedly determining before the season of suggestion from another, that he will not do a certain thing, will not take a certain pose, or give vent to certain words, and all the psychic power in the world cannot make him do it.

This principle of anti-suggestion must always be reckoned with in the following of this practice.

One step further and this desultory effort to set forth some of the uses and to make clear some of the methods of hypnotism on a rational basis is done.

The subjective mind of one person is also influenced by and may



be brought into touch with the subjective mind of another. Just as far as one is able to set aside and to hold in abeyance his own objective mind, just so far is he able to bring his own subjective mind into intimate contact with the subjective mind of another, provided the objective mind of the other is also in abeyance, leaving the subjective mind ready for suggestions and contact.

Telepathy is simply the contact of two subjective minds. Mind-reading is the same thing in a little different form. The one hundred and thirty-eight undoubted cases of telepathy collated by Flammarion and related in his L'Inconnu can all be explained by this hypothesis as above stated.

One of the indubitable proofs of this is the fact that a person who is habitually hypnotized by one and the same operator at last becomes so much under the control of the dominating objective mind of the operator that the state may be induced when the two are not in close proximity.

The same holds good for the action of the dominating subjective mind, with the added fact that the subjective mind is not hampered by either time or space in its action.

Hence telepathic communications ought to be most frequent between people who are familiar with each other, whose relationship is so close and intimate that each knows the other well, and so well that the objective mind in both is easily rendered inert by long continued acquaintance, that in fact a habit of close and intimate conference has been formed.

Examination of the reports of authentic telepathic communications show at once that they almost never occur between strangers.

The time allotted to this paper is about exhausted and it is obviously forbidden to pass on to the discussion of clairvoyance, of phantasies, of the visions of the dying, of dreams of spiritualistic phenomena; suffice it to say that all can be explained by this working hypothesis of the dual mind.

Hoping then that some lasting interest may have been aroused in this subject, further consideration is left to those who can easily verify or refute the statements hereinbefore contained.

It is not designed that hypnotism be employed in all cases of neuropathic or hysterical disease, but it is suggested that a clear knowledge of this peculiar influence of mind upon mind, of the power of suggestion, and of the methods employed in the use of hypnotism, will very materially aid the general practitioner in many ways and enhance his success in his noble work of healing. (Applause.)

# REPORT

OF THE

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

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"Conjunctivitis," - - - - - - - L. W. DEAN.

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## CONJUNCTIVITIS.

L. W. DEAN, M. D.,
UTICA.

I shall not hope, in this paper on so time-worn a subject, to present any new truths in the etiology or pathology of this disease, nor yet anything especially new in the treatment of it, but I shall try to speak a word in favor of internal treatment by medicine which seems to be largely neglected by the majority of physicians. Local treatment is of itself very valuable, but the combined is much more so. In no book of the older school, to which I have had access, have I seen one word as to the necessity, or good to be derived from internal medicines in pathological conditions of the conjunctiva. The external parts of the eye seem to be wholly ignored as a part of the body. This being the case with the major part of the profession, it is not to be wondered at that the laity follow very largely in the line of this teaching, and smile broadly when they are offered some medicine to take for an inflamed eye. As illustrative of this I cite a case, and a little of the conversation which would not do to repeat in polite society. The patient—a large, coarse man—presented himself suffering considerably with a severe traumatic conjunctivitis. After careful examination I could not find the offending cause and prescribed aconite and cold water bathing. The patient said: "What the hell is the good of taking medicine for a sore eye. I want something to put in to cure it?" I prevailed upon him to try this course, as he would find his eye as much a part of his body as his lungs or stomach, if not quite so large. Some months after he presented himself for treatment again, for some other ailment, and remarked, that he had a hell of a lot of confidence in me since I cured his eye with those little pills. And let me say here, that I believe if we can only get people within the influence of those little pills, we can usually give them a lot of confidence.

In my observations in the old-school clinics in New York, I have never seen a medicine prescribed internally for any form of conjunctival disease. I think it can be safely stated that any of the milder forms of conjunctivitis can be cured with internal medicine alone. This being the case then the combined local and internal treatment must hasten the cure, and be better and more logical treatment than local applications only.



The conjunctiva.—The delicate mucous membrane lining the lids, covering the sclera, and joined by loose folds at the back, known as the fornix, is very richly supplied with nerves. By reason of this the eye is very sensitive to any irritation, and most of the pathological conditions produce pain, more or less intense. The blood supply to the conjunctiva is as large as is the nerve supply, hence any irritation from whatever source quickly sets up an hyperæmic condition, which, if it be intense enough, progresses to inflammation with exudation, and the rest of the conditions of conjunctivitis.

What are the causes which lead to hyperæmia and the milder forms of conjunctivitis? Living in badly ventilated houses, working in foul air, as in the crowded sweat shops of the large cities. Smoky and dust laden atmospheres. It has been reported that in New York a great increase in conjunctivitis was observed this summer, attributable to the use of soft coal, and it is certain that nearly all the inhabitants of large cities past middle life have chronic conjunctivitis from the dust which is always being whirled about the streets. Foreign bodies, drafts of very cold or very hot air, hay fever, or any acute form of phinitis. Uncorrected errors of refraction, working in too strong lights, as under the arc light, or the white light of the Welsbach mantle, especially if reflected by too brilliant a reflector, and also the exanthemata usually cause more or less marked irritation. The first symptoms of the disease are dryness and heat of the eyes—unless from traumatism—increased redness of the palpebral conjunctiva, later spreading to the bulbor conjunctiva. A feeling, as of sand under the lids, with smarting, tiredness of the eyes, and photophobia to a greater or less degree. Succeeding this condition we have lachrymation with exudation of mucus, and later possibly of muco-pus. Blurring of vision, with dark spots before the eyes, caused by flakes of mucus floating over the pupil, now takes place.

Treatment of this condition requires, first of all, that the cause be found and removed as far as possible. The removal of the cause, however, is not always possible, especially in the large cities, where people are compelled to work and sleep in foul air, and to live on food which is not of the best. All errors of refraction should be corrected, foreign bodies removed, nasal conditions corrected as far as may be, and if due to too much white glare, a pair of pale blue or violet glasses worn.

Aconite is the first remedy to be thought of for conjunctivitis from foreign bodies. Also in the early stages from a cold developing from exposure to cold, dry winds. Rhus is also an excellent remedy for traumatic conjunctivitis. Also for colds, or rheumatic forms from exposure to wet. Euphrasia, allium cepa, dulcamora, chamomilla merc., ars. alb., hepar sulph. puls. All are serviceable, each in its

own sphere, but a careful looking into the causes and conditions may lead to the selection of a remedy much more suitable than any of these.

As a local application, cold water probably is the most efficacious, and by cold water is meant ice water. A solution of adrenalin chloride 1-5000, will relieve the hyperæmic condition, and if dropped in the eye once in two or three hours will very much hasten a cure. Boric acid solution, eighteen grains to the ounce, is valuable in the acute forms, and also in the chronic forms of this disease. Zinc sulph. one gr. to an ounce, camphor water, cocaine, one per cent. in sat. boric acid solution makes a good local application to relieve pain. This is especially good in traumatic conjunctivitis. Patients should be warned as to the use of towels, and wash dishes, that where there is a discharge from the eyes that the disease is contagious, and that great care must be exercised not to spread the trouble. This is true of all acute forms and especially so of purulent conditions.

The follicular variety of conjunctivitis is often mistaken for trachoma, and occasionally, both forms are seen in the same eye. Usually the location of the disease is a good guide as to the variety. Follicular conjunctivitis being found first in the fornix of the lower lid. Trachoma almost invariably in the palpebral conjunctiva of the upper lid. The appearance of the follicular variety is peculiar, in that the follicles are distended and lie along the fornix in rows parallel to the edge of the lid, like rolls of small sausage. It may extend to the upper lid, where the same sausagelike formation will be found in the fornix. This disease is of slow growth, and may extend over years and when finally it has left it leaves no trace on the lids, as does trachoma.

This disease differs from other forms of conjunctivitis, in the small amount of apparent disturbance. Pain being very slight, photophobia scarcely noticeable, and no discharge to speak of. It results from vitiated air and bad hygienic surroundings, and is, therefore, very prevalent in over-crowded institutions, as charity schools, orphan asylums, etc.

Treatment consists, first of all, in plenty of good fresh air and wholesome food. Nat. mur. is beneficial internally. Also sepia or any medicine which the constitution of the patient may seem to require. Scrubbing the lids with bichlor 1-5000 twice or thrice a week will hasten the condition to a favorable ending. But the quickest and best results are obtained by pressing the contents of the follicles with Knapp's roller forceps. This may be done under 10% cocaine with most children. The after-treatment consists in ice packs to the eyes for twenty-four hours, and aconite internally. The ice treatment, however, seems not always to be necessary, as in a great many cases treated by the roller method at the Five Points House of Industry, by Dr. J. B. Palmer and myself. No after-treatment was used, and every case made a quick recovery and the results were good in all cases so treated. This form of conjunctivitis is not considered to be contagious.



Purulent conjunctivitis is exceedingly contagious and is, with the exception of trachoma, the most dangerous of all the acute forms of disease of the conjunctiva. This disease is classified under two heads, but is the same condition identically only found in different ages. Ophthalmia neonatorium and gonorrhœal oph, neon. comes usually from the secretions of the maternal canal during birth, and shows itself on or about the second or third day. If it comes as late as the fifth day it has been infected from cloth used in washing, and is, therefore, due to the uncleanliness of the attendant. Crede introduced the plan of dropping into the eyes of every child at birth, a solution of nitrate of silver ten grains to the ounce. By so doing he reduced the per cent. of cases of disease from this source to about one-half of one per cent. in this hospital. In the adult the gonorrhœal ophthalmia is due usually to the carelessness of the individual, and to his untidy habits. It is often, however, contracted from towels in public places. Another very common source in large cities, and one which brings numbers to the clinics for treatment, is the public baths for the poor. Those with and without gonorrhœa go for a bath. The virus from the gonorrhœal patient floats on the surface of the water and is splashed into the eyes of the would-be clean. The gonococcus has had his bath, too, and though somewhat weakened in constitution thereby, is still able to do business.

What shall the harvest be, is readily told at the various eye clinics in the city. The very first symptoms of this form do not differ, except in intensity, from those of simple conjunctivitis, but it speedily passes that stage. Photophobia becomes very marked. Intense lachrymation starts in and very soon muco-pus is secreted in such quantities that it runs down over the face in ropes. The lids become swollen and tense, of a deep, angry, purplish red. Complete ptosis takes place. The conjunctiva becomes greatly infiltrated and swollen, so that the cornea sometimes looks like a sunken spot in the anterior part of the eye. No one, not having followed up these cases, can have an adequate idea of the amount of muco pus one small eye can secrete hour by hour. To say that it does so by the spoonful is not exaggeration.

The great danger in this disease is from the involvement of the cornea, either from maceration by the pus, or from nutrition being shut off by reason of the intense chemosis, or by direct action of the gonococcus. The period of incubation lasts from a few hours to three days. The more recent and virulent the gonorrhœa, the more fierce will be the disease. If seen early a strong solution of nitrate of silver, twenty to thirty grains to the ounce, brushed on the lids, and carefully applied in the fornix, then neutralized with salt solution may abort or cut short the attack.

If only one eye is involved the good eye must be carefully washed with bichloride solution 1-5000, and hermetically sealed with a watch glass and adhesive plaster.

The patient must be put to bed, and ice packs kept constantly on the diseased eye, always keeping careful watch of the cornea,

and at the first appearance of haziness, the ice packs discontinued. The eye must be kept free as possible from secretions, and this will occupy the time of a good trained attendant. This requires great care in the doing, as the cornea may be abraided in the process of cleansing if the very utmost care is not exercised. If this should happen, the consequences are very likely to be the loss of the eye.

Aconite, in the beginning, is one of the best remedies, afterwards hepar, rhus, merc, arg. nit., etc., as they may be indicated. If the cornea becomes involved calc. hypo. phos. will sometimes save it.

Local applications of protargol 5% or 10% every two to four hours, washing the eye with chlorine water diluted, merc. corr. sol. 1-5000, boric acid sat. sol. or permanganate of potash sol. if the cornea is not abraided. Arg. nit. in strong sol., twenty to forty grains to the ounce, brushed on the lids with camel's hair brush and carefully washed off with salt in solution; once daily. The course of the disease under the best of care and treatment will be from three to six weeks. (Applause.)

## DISCUSSION.

C. E. LANE: I wish to call attention to an accident that occurred at our place from a trolley line breaking. There was a great flash of electricity from the trolley wires, and that night there were several of our physicians called out—I think this happened at three or four o'clock in the afternoon—and several physicians were called to attend cases of conjunctivitis, which were extremely painful, some eight hours after the accident occurred. In our small place we probably had fifteen or twenty cases of people that had been in the vicinity where the trolley wire broke and that night were found to have a very painful conjunctivitis. I will say that most of those were treated by applications of boracic acid, which did no good. Hot and cold applications seemed to do no good, so I really had to resort to a drop of cocaine, four ounce solution, and as a usual thing with just one application of that, followed by boracic acid, it cleared up in three or four hours.

PRESIDENT MOFFAT: Was this due to the flash of light or from being near the electricity?

C. E. LANE: Probably the excessive light produced it.

J. IVIMEY DOWLING: Referring to conjunctivitis of this sort, a case came under my care recently from an irritation of the retina, practically a mild retinitis, due to exposure to an arc light, and I wondered if that could not possibly have been something of that sort, irritation of the retina. Was there any discharge connected with this, doctor?

C. E. LANE: Not a bit.

J. IVIMEY DOWLING: The treatment I pursued in this case was to dilate the pupil with atropin, and the case got along very well. It was merely a mild retinitis due to exposure to an arc light, somewhat similar to that which the doctor speaks of.



# REPORT

OF THE

# BUREAU OF PÆDIATRICS.



## A CONSIDERATION OF SOME PATHOLOGICAL CONDITIONS OF THE BLOOD IN EARLY LIFE.

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BUFFALO.

During the last ten years an immense amount of time and labor has been spent by students of research, in this country and especially in Europe, on examinations of the blood, both chemically and with microscope. But at the present time our knowledge, concerning the diseases of the blood and its conditions, as associated with other diseases, is very unsatisfactory. Most of these examinations have been made with adult blood, consequently we know very little of the blood in early life. In recent years the literature of blood diseases in general has been much increased, yet that pertaining to the blood of infancy and early childhood is small in comparison; and even the little that has been written on the subject is wanting in exactness.

I have not the time in this paper to consider the various terms used to designate the elements of the blood, but the subject is now receiving so much attention that these terms will soon be as familiar to all of us, as are those now used in clinical medicine. Neither is there time to go into detail concerning the normal and abnormal conditions of the blood in early life. The general methods now employed for making blood-counts, also the use of the hæmoglobinometer for estimating the percentage of hemoglobin, is very clearly described in recent text books on diseases of the blood.

There is an opportunity, however, for the members of this society to make investigations along these lines of scientific research. We should not depend entirely for our knowledge of such matters to the old school, but should pitch in and "down" the oft-repeated saying that "we are unscientific". In this paper I have only time to touch upon four pathological conditions of the blood, namely, (1) anemia, (2) hemophilia, (3) purpura hemorrhagica, and (4) scorbutus.

In the vast majority of cases anemia is merely a symptom of some common disease of the body or of an individual organ. It is a condition of the blood produced by a decrease in the richness in either the corpuscular elements or in the amount of hemoglobin. This decrease may be brought about by some primary disease in either a blood-making or a blood-destroying organ; or it may come on secondarily from some general or local disease that interferes with normal absorption and assimilation. Those diseases that occur without any apparent cause, other than disease of a blood-making or a blood-destroying organ, are spoken of as primary anemia's. Under this class of anemias we have, chlorosis, progressive pernicious anemia, lymphatic anemia, and leukemia.

We will consider under the anemias a primary affection termed chlorosis. I hear some of you say that chlorosis is a disease attending the girl who has passed puberty; but it is a mistake not to think of this disease as occurring in the early periods of life. Indeed, it is very often met with before the period of childhood has advanced. Much has been written, and at the same time disproved, concerning its etiology. A very satisfactory explanation of it is, "that the excessive destruction or imperfect formation of hemoglobin is due to, either the defective absorption and assimilation of iron from the intestinal tract, or to the absorption from the bowel of poisonous principles of hæmolythic properties. Age and sex stand forth as prominent factors in its causation. Most cases occur in young women; so much so, in fact, that if a suspected case occurs in a male subject, a diagnosis should be carefully guarded until the case has been under observation some time. Heredity alone exerts an important influence in the production of some cases. Virchow is of the opinion that it depends upon developmental imperfection of the genital apparatus; but this view can hardly be considered, when most all of the cases begin to improve under proper hygienic and medicinal treatment. Habits of living also play an important part in its causation; for example, the overworked young girl in the department store, who has very little time for out-door exercise, or, if she does have her evenings, spends all the time in dancing or other harmful exercises.

I am of the opinion that the menstrual disturbance accompanying this disorder of the blood, is a result rather than an exciting cause.

Pathological examinations, or rather conclusions, are almost nil in this disease, owing to the limited amount of cases that result fatally. Virchow observed the small size of the aorta and its branches in many cases; also, did he find a poorly developed uterus and its appendages.



The symptomatology of this disease is variable. The complaint that induces one patient to seek medical advice may be entirely different to that of another; sometimes it is the shortness of breath that comes on by the least exertion, and again it is the interruption noted in the menstrual periods. The patient will invariably tell you that she has suffered with cephalalgia for a long time and occasionally has fainting spells. Constipation is usually present. A craving for unnatural articles of diet is also a prominent feature. The pallor in chlorosis is usually better marked than in other anemias, owing to the marked deficiency in the blood coloring matter. The preservation of adipose tissue is an important feature of the disease. The skin has a peculiar olive tint, with an ashy appearance about the angles of the mouth; the expression is usually languid, with an appearance of sadness, while the features appear heavy in outline; the pulse is rapid and easily compressible; the apex beat of the heart is plainly visible; auscultation reveals a soft blowing murmur at either the apex or base.

The examination of the blood is usually sufficient to make a correct diagnosis. There should be a marked decrease of the percentage of hemoglobin; there should be a variety in the size and shape of the red blood cells when seen under the microscope.

Prognosis is, as a rule, favorable. The patient must be persuaded to continue treatment until absolute cure is attained; so many stop treatment after the third or fourth prescription, or just when they begin to feel better and obtain relief from their symptoms. Gastric ulcer is a complication that might occur, although it is rare. Permanent diseases of the heart may result in long continued cases; therefore, each patient should be cautioned as to the weakness of the heart, and an avoidance of undue exertion.

(The treatment of any of these diseases will not be considered in this paper.)

Hemophilia is characterized by obstinate bleeding, and very often associated with swelling of the joints. This condition may manifest itself at any time from early infancy to the end of life; it is simply a morbid condition characterized by a tendency to bleed spontaneously or from some traumatism. Individuals who are liable to bleed in this way are said to have a hemorrhagic diathesis. People with this tendency are to be found in all localities and in every walk of life, and they are usually healthy in appearance, having a very soft skin. The real cause of this condition is, however, unknown.

Post mortem in these cases has discovered an unusual thinness of the walls of the blood-vessels, but nothing definite has been found by microscopical examinations. Swelling of the joints is due to hemorrhages into the articulations and the surrounding tissues; it has yet to be determined whether the hemorrhage is due to condition in the character of the blood, which prevents the formation of thrombi.

Nothing, perhaps, in the child's birth will lead you to discover this condition, not even in the ligation of the unbilical cord, for it is usually not made manifest until the child's growth and strength lead

him into accidents, such as bruises, cuts, scratches, etc. Epistaxis is the most common experience that leads to its detection.

It is not an uncommon occurrence to find hemorrhage of the gums at the eruption of the second crop of teeth. The joints may be found swollen, resembling rheumatism. Slight cut may give rise to severe hemorrhage. Long continued bleeding may follow the extraction of a tooth. The bleeding is nearly always from the capillaries, and a gentle oozing from these vessels may persist for hours, or even weeks. The subjects of hemophilia are very sensitive to the cold air, easily chilled and experience pains in the joints.

The prognosis should be guarded, because, from the nature of the disease, the patient is in danger of bleeding to death. No matter how mild the condition may appear, every case should be considered serious. Of 152 cases of hemophilia traced by Grandidier, more than half died before completing the seventh year, and only nineteen attained majority. The most quickly fatal cases are those from extraction of a tooth or epistaxis.

Purpura Hemorrhagica.—Purpura is a name applied to certain conditions in which there are hemorrhages into the skin, or mucous membranes. The hemorrhages are occasionally into serous membranes, or joints, or into the organs of the body. These hemorrhages may be of various sizes; when small, they are called petechiæ; when larger, they are called ecchymoses. Its etiology is very obscure; some authorities claim that it is not a disease of the blood; others say that the disease is of microbic origin. Purpura is not always a primary affection, but can be secondary to other conditions, especially those of an exhausting nature. I found this condition in the later stage of a case of infantile atrophy during the past summer, the hemorrhage covering a large portion of the child's body.

In the simple forms of purpura the disease usually runs a mild course, accompanied by loss of appetite, fever, anemia, and petechiæ in different parts of the body. In the most severe form there are hemorrhages into the mucous membranes and the skin. The disease begins with general malaise, etc.; in a few days large purpuric spots appear on the skin, and later on, hematuria and hemoptysis become troublesome symptoms; from these later developes excessive anemia. The fever is higher than in the simpler variety of purpura, and recovery takes place very slowly, extending sometimes over a period of a month.

The prognosis of these cases in early life is by no means favorable; death frequently follows the extreme exhaustion brought on by great loss of blood, or hemorrhage into the brain. Very malignant cases of purpura may occur and prove fatal within twenty-four hours. It is commonly met with in infants and very young children, and is characterized by the rapid development of cutaneous hemorrhages; so extensive, sometimes, as to cause death before there has been any hemorrhage from the mucous membranes. There are only about eight cases of this malignant form on record.

Scorbutus is a constitutional disease produced, in most cases, by improper feeding, and by the lack of fresh food for the patient. It has the well-defined symptoms of swelling, excessive tenderness and pain on motion in the lower extremities, and spongy gums, the same as found present in stomatitis ulcerosa. It is further characterized by its rapid recovery under corrected diet and administration of orange juice.



The first case of infantile scurvy was reported by Jalland; but England has been the source of most of the literature of scurvy in children. To W. B. Cheadle and Thomas Barlow, of Great Ormond Street Hospital, is due the credit of having first shown on clinical grounds the true affinities for this form of infantile cachexia, and demonstrating the anatomical nature of the disease from post-mortem examinations. Prior to the work of these observers, infantile scurvy had been regularly regarded as acute rickets, or gone astray as purpura hemorrhagica.

If you examine the dietary of every scorbutic child you will find most every food that could be employed. There is no doubt but that the sterilization of the milk has been the cause of many cases of scorbutus. Children who were placed on proper food mixtures have become scorbutic owing to the food having been sterilized too long; this is a fact; and the same cases have recovered when the over-sterilization of the food was stopped. Scurvy is rarely found in nursing infants.

Surroundings seem to have very little to do with its causation. Most cases occur in private practice, in which the surroundings are good; locality has no influence, for cases have occurred in all parts of this country. Scurvy can be found in any section where improper feeding is permitted. The disease is usually seen between the sixth month and the end of second year.

The symptoms of infantile scurvy are those of a slow and progressive cachexia. The infants become anemic, and present symptoms of gastro-intestinal disturbance. Slight fever, loss of appetite, and excessive sweating about the head, are early symptoms. The first and most important symptom is a sensitive condition of the bones; as the disease advances, the child expresses fear that he will be handled, but when lying quiet he does not seem to be suffering pain. As the disease advances very marked symptoms develop; the limbs become swollen; the bones of the legs are the ones usually effected, although the bones of the forearm are sometimes inflamed. There is usually great tenderness over the parts effected, but no great amount of heat is noticed.

If the infant has not cut any teeth, the mucous membranes of the gums will be found in good condition; but if a tooth is pressing on the gum and is almost through, we will find small areas of congested mucous membrane at this location. The child keeps the limbs perfectly still, and if you did not know that pain prevented him from moving the limb, you would surely think he was paralyzed.

The lesions found in these cases are well given in Northrup's report of the autopsy on his first case, and I will quote this in its entirety:

"The child was emaciated, its eyelids swollen and ecchymotic. The

gums were prominent, spongy, dark, covered with dried blood, the lips blood-stained. The pale, thin face, with two black eyes, gave a most striking appearance to the dead baby. The main interest lies in the condition of the legs. Left thigh symmetrically enlarged, larger than the right, although both were obviously above normal in size. Left femur was normal at its upper extremity, epiphysis, and end of shaft. The lower half was invested by a black, grumous, subperiosteal layer of blood two or three millimeters thick. The lower epiphysis was detached; the lower end of the shaft lacerated, eroded, and soft, lying loose in the black, disintegrating blood clot. The femur of the right leg was surrounded for its lower two-thirds by a thinner, black, subperiosteal blood layer. The lower epiphysis was not detached, both it and the shaft were congested. No hemorrhage into joints. The right and left tibiæ were surrounded by a thin, dark, hemorrhagic layer beneath the periosteum, and the proximal portions of both were congested. The fibulæ and bones of the upper extremities were normal. Microscopical examinations of the bone disclosed no syphilitic or rhachitic changes, and no inflammatory changes in bone or periosteum. The softened, macerated bone gave no evidence of suppuration, but there was moderate congestion of the fellow femur and upper extremities of the tibiæ. A small amount of blood, dark and disintegrated, was found in the intestines; no lesion discovered."

The diagnosis is by no means easy. Careful differentiation from rheumatism, rhachitis, purpura, and syphilis must be made in all cases.

Absence of heat and extreme tenderness of the joints, and a decided rise of temperature, will be enough to diagnose scorbutus from rheumatism.

The diagnosis from rhachitis is to be made by the presence of hemorrhages, and the intense pain above the epiphysis, also, the absence of the rhachitic rosary as a constant symptom of the latter disease. In scorbutus, if teeth are present, we have stomatitis ulcerosa.

Purpura is easily differentiated by the absence of the characteristic osseous symptoms found in scorbutus. It is only in the severer forms of purpura in which the joints are effected, that it could be mistaken for scorbutus.

Syphilis has not the extreme tenderness of the bones, the hemorrhages, and the peculiar condition of the gums around the teeth.

The prognosis in scorbutus is favorable, if treatment is begun very early in the attack, before the child has been much reduced in weight. Much depends on the vitality of the child. If the case is left without the proper treatment for any length of time, the infant's chances for recovery are indeed poor. Death very often follows exhaustion of the patient.



## DISCUSSION.

GEORGE F. LAIDLAW: I have had great pleasure in listening to the paper, and, on the ground of clinical experience, cannot controvert it. I can simply congratulate the doctor on compressing so much useful information into so small a compass. His calling attention to disease of the blood in infancy is a most useful procedure; for, if I judge from the recent medical literature, there is, at present, a considerable darkness in the minds of the most of us on the topic of blood disease. There is not only darkness, but a great deal of misinformation. I do not speak as an expert in children's diseases, but, as a laboratory man, I am called upon to examine bloods in a number of instances; and I find, amongst my colleagues, as well as in their writings, a considerable need for accurate information. The first thing that I should say in reference to the doctor's work is that the study of the blood is quite new; that a book two years back is almost out of date; that, in our literature, there are many statements that will bear further investigation, especially if a man takes the average text-book, a microscope and a blood specimen, and endeavors to make a diagnosis, he is just as apt to come to a wrong conclusion as a right one, in the light of our present information. There is one error in regard to the examining of children's blood which is commonly made, and that is in the matter of leukocytosis. Perhaps the most reliable thing in blood examination is leukocytosis, which indicates the presence of suppuration, or of infective fever, or of some septic infection. Now, when you apply that to the blood of children, you find that almost all children have leukocytosis, and the younger the child the more apt its presence and the more persistent its condition. In the very young it is probably a digestive leukocytosis, as they feed every two to three hours; and, for two to three hours after a meal there is always a digestive leukocytosis, so in most young infants you will find from 20,000 to 25,000 leukocytes to the cbm., and still the blood is entirely normal. Another point in the examination of children's blood is the ease with which they simulate intense and fatal anæmias. The child's blood is very near that of the fœtus. In secondary anæmias and in pernicious anæmias the blood returns to the fœtal state, in respect to presenting a large number of nucleated red cells, a large number of deformed and undersized cells, a large number of myelocytes, and a large number of lymphocytes. In the ordinary anæmia, perfectly curable in an infant, you will find a picture of the blood which, if found in an adult, would be called absolutely fatal. About the seventh month of fœtal life, the blood undergoes great changes and begins to assume the adult form; but it is not until the second year that it assumes anything like the adult number of corpuscles, and that is especially true of the lymphocytes, which are coming up at present as a diagnostic feature in tuberculosis. So that, while in the adult, if we find 60% of lymphocytes and only 40% of the polynuclea, we think that man is pretty sick, we think he has malignant disease or tuberculosis; but if we find exactly that same thing in a child two years of age, we

say that is exactly the normal condition to be found at that age. As the child grows up, the lymphocytes decrease to 30%., the adult average. So that, in examining the blood, it is necessary to bear these points in mind; and, in examining the blood of children, it is, above all, important to bear in mind the fact that our knowledge, at present, is very rudimentary; and, that blood examinations are largely suggestive and complimentary to clinical signs, rather than a means of positive diagnosis. (Applause.)

H. D. SCHENCK: Perhaps a case of hemorrhagic purpura where the child only lived five days may be of interest as showing the rapid degeneration that sometimes happens in infants otherwise apparently healthy. This child was born on Friday, September 5th, after the parents had been married for six years. This was the first pregnancy, however. The mother had had albuminuria to a considerable extent and many severe nervous symptoms during the later stages of pregnancy. I think she was taken in labor on Thursday, September 4th, and very little progress had been made by early Friday morning, when the doctor in attendance gave a hypodermic to see if he could not get better pains after she had rested for a time. She slept for several hours, and, in the meantime, a consultant from Brooklyn was called. When he arrived Friday morning he found the uterus very flabby and so he could move it around in almost any position in the abdomen to the right or left. He administered an anæsthetic and delivered what proved to be twins. The first one was delivered alive without very much trouble, and he turned and delivered the second one as rapidly as possible, but it was dead. The mother lost a great deal of blood, and he gave her his first attention, while the nurse had the baby in charge. He only noticed that there were a number of bruises about the face, apparently made by the forceps, one, especially, over the right eye at the edge of the orbit, which had apparently resulted from the edge of the blade of the forceps. By the next day the blood had exuded into the orbit and forced the eyeball well outward. When I saw the child on the following Tuesday, September 9th, it had forced the eyeball further outward so that the posterior part of the eyeball was two-thirds out of the orbit, and the lids could not be closed. The pupil still reacted to light, and so far as the ophthalmoscopic examination revealed the condition, the vision was not affected, the interior structures of the ball appearing normal. There was continual oozing of dark, grumous blood from the break in the skin at the outer canthus, and the lids were stiff, swollen and dark purple in hue. There was a slight hemorrhage from the mouth, not from the gums, but on coughing. We were unable to determine whether it came from the stomach or the lungs. During the next twenty-four hours there were bloody stools, and the child died on Wednesday evening, September 10th. At the time of his death his body was covered with ecchymotic spots from top to bottom, and his back was almost one black mass from the flow of venous blood into the tissues. He was given crotalus and hamamelis, but they had no effect whatever. The child seemed to be perfectly formed and healthy otherwise.



# INFANT FEEDING.

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ROCHESTER.

The provision of suitable nourishment for infants which are deprived of the sustenance nature intended for them is a problem of the utmost importance. Indeed, there is nothing in preventive medicine which will yield the investigator more satisfaction than the results which may be obtained by a careful study of this subject. When we consider that an infant is in its early life an animated stomach, happy and cheerful or restless and crying, according to the condition of that important organ, the value of such study is further enhanced. Furthermore, the child's physical well-being depends in a large measure upon the food materials which are furnished for the up-building of the various tissues of its body. In this all-important matter, the constituents and percentage composition of a proper infant food, we must be guided solely by nature's product, mother's milk, rather than by any preconceived idea as to what ought to agree with and nourish a child according to mere test tube theories or to the advertisements of enterprising manufacturers of proprietary foods.

The composition of mother's milk varies, of course, with the diet and with the individual, but the following may be considered as a fair working basis in comparison with cow's milk:

| | Human Milk. | Cow's Milk. |
|---|---|---|
| Fat ..... | 4 % | 4 % |
| Sugar ..... | 7 % | 4 % |
| Proteids ..... | 1.5% | 4 % |
| Salts ..... | .2% | .7% |
| Water ..... | 87.3% | 87 % |

The fats are necessary for the development of bone, nerve, adipose tissue and for the production of heat. Sugar, especially for the growth of adipose tissue and the production of body heat. The proteids or the casein contribute to the growth of the body cells as of the blood, organs and muscles. The salts are especially needed in the formation of bone.

The chief trouble with cow's milk is in the amount of casein which it contains. By the action of the gastric juice the casein is curdled and if the milk be given undiluted large, hard curds are formed which are almost indigestible, and cause colic, vomiting and undigested stools. To render these curds smaller, more permeable by the gastric and intestinal fluids and hence more digestible it is necessary to dilute the milk to an approximation of mother's milk.

But first as to the milk supply. It should be the best obtainable and from tuberculin tested cows. That from a large number of cows

is more constant in proportions, but on the other hand, unless very rigidly inspected there is increased danger of disease in a large herd. It seems to me that milk from four or five very carefully tested cows would be preferable to the milk from a large herd. All milk to be fit for infant feeding should be bottled at the farm under the most rigid precautions to preserve cleanliness. Otherwise it at once becomes a culture medium for myriads of bacteria which hasten its change toward acidity and very soon render it unfit for use. To prevent this the utmost degree of cleanliness in the stables, the udders, milking and bottling is required. Rapid cooling of the milk is also essential. The top milk from that thus carefully bottled and delivered fresh every morning furnishes a fairly constant fat percentage upon which to base our modification.

A bottle of milk after standing a few hours may be roughly divided into three zones, as follows: the upper one-fourth or eight ounces contains from 10% to 12% fat; the middle two-fourths or sixteen ounces contains about 2% fat; the lower one-fourth being practically fat-free milk, that is, containing the normal amounts of casein, sugar and salts but no cream. The following table of fat percentages will be found of value:

| | |
|---|---|
| Upper six ounces of top milk..... | 14% fat. |
| Upper eight ounces of top milk..... | 10-12% fat. |
| Upper ten ounces of top milk..... | 8-9% fat. |
| Ordinary milk ..... | 4% fat. |

Having decided upon which of the above percentages will be most convenient for the preparation of the modification which we desire to make, the amount is removed from the bottle with a cream dipper made for the purpose and the diluent added with sugar and salt to form the desired percentages. The diluent may be either boiled water, or oatmeal, wheatmeal or barley water. Any of these may be made by boiling one tablespoonful of the meal in one quart of water for an hour, adding more water to replace that which boils away. Add a half teaspoonful of salt and strain through gauze. These weak gruels are much better than plain water for dilution, especially after the first few months when the infant acquires some degree of starch digestion. They cause smaller and light flocculent curds when the milk comes in contact with the gastric juice and thus render digestion easier. Oatmeal and wheatmeal water also have a gentle laxative effect which is, in most cases, very desirable; but where this is not needed barley water will answer well.

Suppose we wished to modify milk for a child of one month and wished to begin with a mixture containing, fat, 2.5%, sugar, 5%, proteids, .8%. To accomplish this dip off eight ounces of top milk; take of this 12% milk six ounces and dilute with twenty-three ounces of boiled water in which has been dissolved one and one-half tablespoonfuls of granulated sugar and a level one-half teaspoonful of salt. By dilution we have brought down the fat and proteid percentages, and by addition have raised the sugar to what we wished. Thus from these simple data almost any formula may be worked out with an



accuracy sufficient for all practical purposes, and when the right formula has been found the mother or nurse may easily be shown how to prepare the milk. As soon as the day's supply is prepared it should be bottled in as many nursing bottles as will be required for the next twenty-four hours, putting just the amount necessary for one nursing in each bottle. Plug with cotton and keep in the refrigerator until needed.

In very weak children who cannot digest the milk proteid in sufficient amount to maintain their growth, the white of a fresh egg beaten and dissolved in a few ounces of water and added to the dilute milk mixture will furnish the necessary proteid in an easily assimilable form.

Nothing has been said of the sterilization or pasteurization of milk, because, if the supply be reliable, it is much better for the child that these procedures be omitted. The former renders the milk much more difficult of digestion and the latter is of questionable value. However, when one has reason to suspect the cleanliness of the milk and better cannot be had, pasteurization is by all means to be recommended.

If the child's digestion is so impaired that no milk mixture of sufficient strength to supply the necessary nourishment can be retained partial peptonization is indicated and will be found to be of great value. A double boiler should be procured, such as is used in cooking cereals. Put the modified milk mixture in this and add the peptogenic powder as directed on the bottle. Have the water in the outer vessel warm; heat the mixture to be peptonized to blood heat and set it in the outer boiler so that it will be kept warm for ten or fifteen minutes; then place over the fire and boil until the milk in the inner boiler is on the point of boiling, which will be after the water around it has boiled for about five minutes. Then cool rapidly, bottle and place in the refrigerator until needed. This procedure practically sterilizes the milk without making it more difficult to digest, because of the peptonization which has preceded the heating. A weakling previously unable to retain anything on its stomach will stop vomiting and soon begin to gain in weight and strength on peptonized milk. It is well to gradually reduce the amount of peptogenic powder used and the time of peptonization until none is needed. If indigestion recurs it may be repeatedly resorted to without harm to the child's digestive apparatus. If it be desirable to increase the proteids by adding albumen water or liquid peptonoids these may be put in after the mixture has been peptonized and cooled.

In the addition of sugar I have followed the recommendation of Dr. Jacobi that cane sugar be used in place of milk sugar, and his arguments in favor of it appear to be well justified by experience. The milk sugar in any milk at once begins to undergo lactic acid fermentation and the acid change comes more rapidly than in the cane sugar solution. Cane sugar is a preservative and tends in a measure to counteract the acid change. Of course less cane sugar should be used than milk sugar because of its greater sweetening power. In diseases of the alimentary canal there is abnormal

fermentation already present, and hence cane sugar in small amount is better indicated than milk sugar, though in illness of this kind but little of either should be given.

Salt ought always to be added to any milk mixture on account of its stimulating action upon the secreting glands of the stomach and intestines. It also breaks up into another sodium salt and HCl, thus increasing the efficiency of the gastric juice and being especially indicated in conditions of hypacidity. Part of the salt is absorbed directly and stimulates all the vital processes by increasing tissue metalbolism through the elimination of urea and carbonic acid. Salt also prevents the solid coagulation of the curd and thus makes digestion more easy, and by its mild stimulation of the intestinal glands increases their secretions and tends to overcome constipation.

There seems to me but little opportunity for argument as between proprietary or artificial foods and modified cow's milk. Of course, cow's milk can never be made human milk, but its constituents are more nearly the same than any proprietary mixture can be, and by judicious home modification good cow's milk will be found to furnish the most satisfactory food. But occasions will arise where milk will not be assimilated, and be it ever so dilute, will cause colic and vomiting. Here peptonizing must be resorted to for a time. As the strength and the digestive powers improve upon the bettered nutrition the amount of peptonization may be gradually reduced until it is dispensed with altogether, although the digestive power does not seem to be weakened by the continued use of it.

Illustrative of the beneficent results of modified milk, peptonized, I would cite the case of Joseph Smith, age three months, weight five pounds. Joseph was a tenement baby whose mother had no milk for him and no common sense as to how an infant should be fed. As a result he cried night and day and grew steadily thinner and weaker. Indeed, he was reduced to a veritable skeleton upon which the skin hung in folds, while in addition to his other troubles a large, ischio-rectal abscess developed. Hot weather was coming on and the chances seemed very much against him. I at once put him on modified milk of about the following strength, peptonized: fat, 2%; proteid, ½ of 1%; sugar, 3%; two ounces every two hours. At first he seemed too weak to take even two ounces at a time and vomited part of what he did take. Percentages were reduced a little more and the milk peptonized longer. Vomiting became more infrequent, the child slept better and finally began to gain a little in weight, and as improvement progressed the strength of the milk was very gradually increased and he continued to gain slowly. The abscess was opened and subsequently healed. Toward the last of June he passed from my observation, but when seen again in the fall was a strong and hearty child, seemingly as well able to withstand the indiscretions of tenement house life and diet as any child.

In the above case there was no trouble with diarrhœa, but rather constipation, which was somewhat improved by increasing the cream percentage. A subsequent case, however, of a child of six months



which presented a very similar picture, had frequent, loose, undigested stools; great restlessness, colic and almost constant crying. The food had been canned condensed milk diluted by guess. All food except egg water was stopped for twenty-four hours and the diarrhœa and colic ceased; then a very dilute peptonized milk of about this percentage: fat, 2%; proteids, ⅜ of 1%; sugar, 2%. When this was well borne the white of one fresh egg was added to the day's amount after the peptonizing process was completed and the milk cooled, in order to supply more proteid in a more assimilable form than that of milk. Later, a tablespoonful of beef peptonoids was added to the day's feeding with good results and when this case passed from my observation it was markedly improved, although at first it seemed to be a clear case of marasmus. In both of the above cases I prescribed symptomatically as well as I knew how, but potencies will avail little if proper food is not supplied, which is within the child's power to digest.

Constipation in children, as in adults, is such a common complaint that it is well worthy of consideration, and as in adults the most satisfactory and lasting results are to be gained from regulating the diet. Good digestion is necessary to proper intestinal action, and hence, the first indication is to find the right milk formula. This having been found a slight increase in the cream percentage will often have a gentle laxative effect; or raising the sugar percentage to about 7%, provided the latter does not cause flatulence. The necessity of avoiding flatulence cannot be too strongly emphasized, for if the intestines are distended with gas the muscular coat becomes stretched and weakened, and even if peristalsis is not destroyed its efficiency is lost on account of the distension. In that form of constipation depending upon absence of sugar and a superabundance of casein, a teaspoonful of sugar in a couple of ounces of water or oatmeal water will often be all that is required to move the bowels. One of the best adjuvants is the use of oatmeal water as a diluent, made as directed for the modification of milk. Milk diluted with oatmeal water forms a fine, flocculent curd which is easily digested, and easy digestion with a minimum of gas in the bowels favors efficient peristalsis and regular evacuations. After the eighth month a little orange juice will be found an excellent laxative and a little later prune juice, or baked apply pulp may be given in small quantities. Regularity in feeding and in placing the child on stool are two points which must be emphasized over and over, even though they should be universally known and practiced by mothers ere this. Water is as necessary to an infant as to an adult. Milk is the child's food and a drink of water apart from food is as agreeable to a child as to one of us. Fretfulness will many times be quieted by a little drink of water as effectually and with much less danger to the digestion than by poking the inevitable bottle into the child's mouth every time it whimpers.

The diarrhœal diseases of infancy are perhaps the most common and the most dreaded. An acute intestinal indigestion may prepare the soil for infection and a typical cholera infantum result. Here

again prophylaxis is of first importance and in proper diet lies the means both of prevention and in large measure, of cure. It is well known that infants suffer from these disorders chiefly in summer and the reason for this is clear. Bacteria thrive best and develop their toxines most rapidly at the high temperatures which summer brings and at the same time the heat and humidity diminish the child's normal resistance to infection. Any lack of cleanliness in the milking or in the care of the milk enormously increases the number of bacteria in it, and their rapid proliferation renders it unfit for food the more quickly. Hence, in warm weather, if the milk is not peptonized and thus sterilized it should be supplied twice a day, and always in bottles closed at the dairy, thus preventing the further contamination of repeated handlings.

In the prophylaxis of infantile diarrhœas we should look first to the child, to preserve as high a degree of vital resistance as possible. Next, to the milk supply, which must be subjected to the most rigid inspection. As to modification and the amount of milk to be given these are to be determined more by the size of the child and from experiment than from arbitrary rules. Better begin with too weak a formula and have the child hungry for a day or so than to derange digestion at the start.

During dentition the digestive ability seems to be weakened and solid constituents should be slightly diminished in anticipation of this. If, however, the child be poorly nourished and it seems unwise to dilute the milk more, peptonization should be resorted to. In hot weather, too, the digestion is weakened and the milk should be made somewhat more dilute, and sufficient water given to make up for that lost by perspiration.

But even the most careful prophylaxis cannot protect in all cases. Suppose an attack of infectious diarrhœa, with fever, prostration, and stools either green and offensive or containing blood and mucus. The first indication is to stop all food. If the child be well nourished it may well live for twenty-four hours on water and the infection will thus be made the milder. Or egg albumin water, with a little salt, may be used. After forty-eight hours, if necessary, beef peptonoids may be given with the albumin water and later when the fever and acute symptoms have subsided, peptonized milk of a much weaker formula than that given before the illness. Boiled water should be given freely and barley water may be used with the albumin water by way of variety, provided that the child has not previously been fed upon a food containing an excess of carbohydrates. Except in mildest cases milk in any form should not be given for forty-eight hours after the fever has subsided and the stools have become of normal frequency.

In any attack of acute milk infection cow's milk must be stopped, and the more promptly the better. The intestines in such a case are swarming with bacteria, and the continuance of milk supplies them with abundant pabulum for further proliferation, while if the milk is stopped a large proportion perish for want of sustenance. But if no milk, what then? The most important need of the system in



diarrhœal disease is water. If the child will take it full as much may be given per mouth as in health. If the stomach will not retain it enteroclysis must be resorted to and beef juice, beef peptonoids, panopepton or albumin water may be used in this way. The fluid, which is thus absorbed through the colon, is of great value to the system, depleted by the constant drain of watery stools. Entering the circulation it acts as a mild stimulant to the heart and kidneys, diluting the urine and thus increasing the elimination and lessening the irritation of the kidneys. Where there is persistent nausea, if the child can be made to take a considerable quantity of warm water vomiting will follow and thus lavage of the stomach will be accomplished and the nausea relieved.

A little thing, but one worthy of emphasis, is the necessity for absolute quiet and rest in the recumbent position. Rocking or trotting is bad for any sick child and only aggravates intestinal troubles. It is a very false idea of kindness which causes a mother to walk the floor all night with a sick baby, when the thing that baby most needs is absolute quiet. There is also a rather prevalent idea that fresh air furnishes all that is necessary for the treatment of intestinal troubles. As an aid, an abundance of fresh, pure air is very beneficial, but to rely upon it as our only therapeutic measure would be little less than criminal when we have so many drugs of proved efficacy in intestinal diseases. Fresh air, pure and cool, such as may be found at the seaside or at a moderate elevation, is of great value, but the first place should be given to diet, as the thing which most vitally affects the intestinal tract for better or for worse.

To sum up: These intestinal troubles are, to a great extent, preventable and it is our duty to do our utmost to prevent them by directing the feeding of all infants which come under our care. Do not harbor the delusion that it is natural for a teething child to have a diarrhœa and neglect it. Stop the milk at once and regulate the diet for a few days, even in the mildest cases, to insure complete recovery and prevent the more serious forms of enteric infection. In conclusion, there are a few common symptoms of infancy which, if understood, can oftentimes be easily remedied.

Vomiting within a few moments after finishing a bottle indicates that the quantity is too great or that it has been taken too rapidly, owing, perhaps, to too large a hole in the nipple. Tight clothing or handling in such a way as to press upon the stomach may also excite vomiting. It is always a good plan to have a child take its bottle lying on its right side. Trotting or handling a child at all just after nursing are to be avoided.

Regurgitation of a mouthful or two of sour milk between feedings indicates too high a proportion of cream.

Habitual colic is usually accompanied by curds in the stools and requires a still further dilution of the milk or at least of the proteids. If this fails peptonize.

If an infant drains the bottle greedily and cries when it is taken away and crowds its fingers into its mouth, becoming fretful before

the next feeding time, it is evidence that the food is insufficient. Either the quantity or the strength should be increased.

Lingering for an hour or more over a bottle, alternately nursing and sleeping is a bad habit often found in babies accustomed to the "comforter." It may be due to a stoppage of the nipple or to too small a hole so that the child becomes tired. Make sure the nipple is all right and have the mother hold the child and urge it to nurse continuously until the usual amount is taken. If the usual amount is not taken in fifteen or twenty minutes, take the bottle away until the next feeding time. Then the child will be more hungry and will take the milk more rapidly.

Restless sleep is generally due to indigestion, often from too frequent feeding at night, or to hunger.

When a baby vomits a large part of its food omit the next feeding and subsequently give the milk much more dilute than before. Or change to albumin, rice or barley water for a few feedings. If vomiting still continues give nothing but water.

If the appetite fails and the child takes less food than usual, the food should be diluted more, otherwise a slight digestive derangement may be prolonged. When digestion is restored the appetite will return.

The recent scientific investigation of the subject of infant feeding is showing such good results in the more intelligent treatment of digestive disorders that no general practitioner can afford to remain in ignorance of the fundamental principles which this study has brought forth. Guided by a thorough understanding of the abilities and limitations of the infant's digestive apparatus the physician can do much in these disorders, even without the aid of medicine. Let us, therefore, not be found wanting in the investigation and application of these simple principles of feeding, which have been proven so efficient in relieving the sufferings of the little ones whose only language is a cry.

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## DISCUSSION.

J. T. SIMONSON: *Mr. Chairman*, Dr. Daley has covered the ground pretty thoroughly, and leaves very little for me to say in discussion. I had great pleasure in listening to his paper because he went over several points in the feeding of infants in which I am very much interested. Speaking of the modification of milk and of the necessity of educating the general practitioner a little more in the necessity for proper modification, I think the general practitioner is educated too much altogether in the modification of milk, especially in the use of and in the entire dependence on the laboratory. In my opinion, in my own small sphere, and in the opinion of men of a great deal wider experience, the laboratory milk is a decided failure. It seems so easy to take a text-book, ascertain the age of the child, refer to a table giving a series of descriptions, and pick out the percentage



of protein, sugar, etc., and give to a baby the preparation with which the laboratory furnishes you—and then you imagine you are feeding that baby. Now, that baby is not getting milk. It is getting a mixture of the various constituents of milk, but it is not milk, and you cannot make milk in the laboratory. It is not possible to break up any chemical unity into its various constituents, put it together again synthetically in a laboratory and call it identical with the original substance. There are two or three very grave mistakes in that method of feeding. In the first place there are many important differences between cow's milk and human milk besides the mere difference in percentages. It is usually supposed that by diluting the milk, thus cutting down the very large amount of protein substance; adding cream to make up the deficiency after you dilute it, and adding the sugar, that you have produced a milk with the same amount of protein, the same amount of fat, the same amount of sugar—that you have produced a milk which is identical with woman's milk, merely because the laboratory percentages are identical. The fallacy there is that the protein is not the same. The principal protein substances in milk are caseinogen, lactalbumin and lactoglobulin. Now, in cow's milk we have that excess of caseinogen and a smaller amount of lactalbumin. By changing these percentages correspondingly, we think we can find a method which will produce the same amount of lactalbumin in the milk as there is in woman's milk. We will not produce a milk that is fit for delicate invalids. It might do for a strong healthy man, but not for a delicate infant. You not only cut down the caseinogen of that cow's milk, but you cut down exactly what the infant needs, the lactalbumin.

Again, the modification of milk is very untrustworthy indeed, because the percentages of the various constituents of the milk that we receive from the dairy are not identical with the things that we are given in the text-books and which are given for guides in making this dilution. I think the modification of milk, according to these percentages, following them strictly and attempting to get strict results, and wonder why the child doesn't get along, are extremely fallacious, extremely so. The method Dr. Daley spoke of, that of using the top milk, comes nearer to perfection than anything we have as yet. I think we have to have the percentages in mind, we have to know what we are doing, but the supposition that we are giving the child the exact percentages of the various constituents of milk in feeding in that way, is very erroneous indeed, as has been shown many times by chemical analysis of the milks thus produced.

One of the points is the question of constipation. Now, constipation may sometimes be reached by increasing the cream over four per cent. Sometimes constipation may be helped by increasing the protein, strange to say—not decreasing it. Many a child is constipated on account of a lack of protein in the milk. But many times that fails also, and I think there are many cases of constipation that cannot be touched by any change whatsoever in the diet. I believe there are cases of constipation that can only be reached by

homœopathic prescription. (Applause.) I have seen that fail many times. I have seen it fail in my own practice. I have seen it fail in the practice of others, and where the milk is most carefully, most conscientiously watched, where the modifications were followed out strictly, where the milk was about as far as we dared to give it, up to four per cent.—which would make a child vomit—that is, nine out of ten would vomit—where the caseinogen was changed up and down, where the various diluents such as the doctor spoke of, were used—oatmeal—I believe that in a great many cases oatmeal is very efficacious in those ailments—and yet where absolutely no results were obtained at all, and where the only thing it was possible to do in the case was to prescribe for it. Of course you have to feed the child properly. You cannot prescribe for a case properly and feed improperly. Your child must be fed properly first. But given a case where a child is fed properly and you get no results, given a case where it is necessary to resort to cathartics necessarily, and to come down to enemata every day, which are extremely deleterious, a proper prescription will cure that case almost invariably unless there is some mechanical disease. One more thing that enters into this question, is the inability of infants to take milk. Sometimes, no matter how much care you give to the modification of the milk, no matter how you study the needs of the child's system, you have to do more than modify that milk. What is the use of modifying the milk, of changing the food, when the digestive power is not there for anything? The child must have the ability to digest food. I care not how perfect that food is. Of course, if you have a food that is not adapted and is not digested, and you change to a food that is adapted it probably will be digested, providing the trouble has not gone too far. But in very many cases the failure results merely because there is a constitutional taint and constitutional dyscrasia, there is inability to digest anything whatever; and the only thing that will make that child digest, after it is fed properly, is a prescription. (Applause.)

H. C. ALLEN: *Mr. Chairman*, that was a very fine paper, but it was after the laboratory style, and, as the last speaker has said, it does not always work. After about forty years' experience in the treatment of babies and feeding them as best I can, and the best I have been able to do with all the laboratory experience I have come in contact with, I wish to say that the doctor is right when he says you should fit the baby to the food, not the food to the baby. That is where we make many of our mistakes. These babies are just as amenable to constitutional treatment as are adults, and they need constitutional remedies just as much, and sometimes more, than adults, and a great many of them never can be cured by fitting the food to them or by changing the food every now and then. It is a mistake. It is a sick baby. It cannot digest anything. Now, if you stop to think for a moment, these laboratory methods that we are trying to follow are the methods of the other school invariably. They have no constitutional treatment for a baby. They cannot cure a syphilitic, a psoric, or a tuberculous child, with internal remedies.



It is nonsense to them. They know nothing of it, and are not learning, not able to learn. What we need is to stick to our homœopathic text and treat these babies just as we treat other patients, and we will have very much less trouble with our food. (Applause.)

E. B. NASH: *Mr. Chairman*, there is one other thing I would like to call attention to that has not been touched. We must not lose sight of the fact that the baby's indigesion may not rest in improper food, but in some constitutional taint or irregularity in the baby's system. There is one step further to go back, and that is to look after the mother. There are many cases in which the mother is at fault and not the child, where the constitutional diathesis arises from some cause preceding that which now rests in the child, and when that is met by appropriate treatment the child will be cured without any change of food whatever, except to change the quality of the mother's milk. That I have seen happen very many times, and have done it very many times, not only in indigestion but in other complaints. One of the most intractable cases, and one which bothered me as much as any I ever met, a case of eczema of the scalp, was cured by stopping all treatment of the baby and treating the mother, whom I found after a long time was very much out of health. Losing sight in my younger days of the fact that the cause might rest with the mother, I treated the child for a long time without success, but as soon as I turned my guns in the right direction and treated the mother instead of the child, the child got well, and the mother, too.

W. S. GARNSEY: I would like to emphasize one point made by Dr. Daly with regard to the selection of the milk supply. Doctors in country practice and in small cities frequently find parents congratulating themselves that they can obtain, and do obtain, a milk supply from one cow, and that fresh night and morning. They think that is most to be desired. I believe that is a mistake, and that mixed milk from a good dairy is much to be preferred. In support of this I would cite the fact that I at one time had under my care a pair of twins about two months old, and one evening, about two hours after being fed with the milk obtained fresh that evening, one of them was taken with convulsions and died in a few hours, and the second one was taken with convulsions soon after midnight and died before daylight. On investigating the matter we found that the cow had been in heat during the day and had been chased in the pasture, where she was with a herd. Undoubtedly that was the cause of the convulsions and death of both these infants.

W. C. DALY: I only wish to say, Mr. Chairman, that I subscribe most heartily to the remarks that have been made upon the subject of prescribing for these children, as well as prescribing diet for them. The subject of my paper being "Infant Feeding," and the scope of it necessarily large, I purposely omitted anything of a therapeutic nature, thinking there would be plenty in the audience better able to speak upon that subject. (Applause.)

# THE INFLUENCE OF PREPUTIAL ADHESIONS UPON THE NERVOUS SYSTEM.

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CORNING.

It is our purpose in choosing the subject of our paper not to announce some new discovery in medical science, but rather to call attention to a neglected feature in medicine and to elicit general discussion.

It is alleged that the increase of preputial adhesions among the Aryan race is an evidence of physical degeneration which is comparable to changes which are occurring in the wisdom teeth and in the vermiform appendix.

It is obvious to every thinking physician that the Semetic races which require circumcision are not so far mistaken as to the moral and hygienic advantages of this rite as may appear at first thought.

We are just beginning to realize the enormous influence of reflex irritation as a causative factor in disease, and especially diseases of the nervous system. Errors of refraction, nasal hypertrophies are now recognized as causes of epilipsy, headaches, asthma, etc.

A systitis may be caused by a rectal ulcer, and the fact is now quite generally recognized and for some reason overlooked by physicians, that epilepsy, nervousness and enuresis are frequently caused by the irritation of an elongated prepuce and the accompanying retained secretions. It is no unusual occurrence for a little patient to come to the family physician, troubled with enuresis, nervousness, insomnia and hernia. It is useless to give a remedy, no matter how carefully chosen, to remove these conditions until the child is circumcised, and no hernia can be cured when there is more or less straining at urination from this cause.

The late Dr. Sayre, in his book on Orthopœdic Surgery, described two cases of paralysis, one with equi-no-varus, and one with prolapsus of the rectum, which recovered completely when circumcised. Dr. Sayre says: "This subject of nervous irritation and consequent exhaustion from undue genital excitement is one of a vast deal of importance, and has not received the attention at the hands of the profession that it deserves. The pressure continually exerted upon the glans penis by the contraction of the adherent prepuce keeps the organ in an almost constant state of irritation and erection.

Such a constant genital excitement, no matter what its cause may be, whether occurring in a child or in an adult, is certainly detrimental to the best condition of the nervous system. In the class of cases before us this undue genital excitement ends in paralysis, and the consequent deformity varies according to the manner in which the weight of the body is placed upon the foot. A simple mechanical support will restore the foot to its normal position, but the child can only be relieved permanently of the deformity by removing the cause which has given rise to the paralysis."



It is well then in all cases of infantile paralysis, in cases of hernia, prolapsus ani, epilepsy, or convulsions of any kind, chorea, nervousness, enuresis, and even in cases of hip-joint disease, to examine for preputial adhesions.

In the female sex the influence of preputial adhesions upon the nervous system applies with equal cogency. There is this additional feature, viz.: the profound influence of such irritation upon the entire generative apparatus with the consequent uterine hyperæmia and ovarian irritation.

The following case will illustrate: About a year ago the father of a little girl about five years of age, came to me in great anxiety and said that his child was continually rubbing her vulva and though repeatedly punished would resume the act. I asked him to have the mother bring the child to me for examination. I then made an examination and found the mucous membrane in the region of the clitoris inflamed and the hood of the clitoris adherent. The child was brought to me on the following day when I stripped back the hood of the clitoris and removed a large amount of retained smegma. The result has been all that could be wished and from that time on the child has refrained from her unfortunate habit. In most cases an amputation of the prepuce is desirable.

Is it not our duty to examine more frequently for preputial adhesions in females? While the matter is frequently embarrassing for both physician and patients, yet have we done our duty by our gynæcological cases when we ignore this subject? Insanity, epilepsy, catalepsy, epileptoid convulsions and enuresis are frequently results of such reflex irritation.

Many girls who "have gone to the bad" may have been the victims of local irritations which it should have been the province of the surgeon to remove. Have not the members of the medical profession much to teach the moralists as to the best methods of preventing and eradicating vice which they would do well to carefully weigh before they condemn the unfortunate?

# TUBERCULAR MENINGITIS.

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ROCHESTER.

Our appreciation of terms would be small if we could not gather from the words "tubercular meningitis" their significance, even though the privilege of observing the clinical course of this disease had been denied us.

Tuberculosis has shared somewhat in the progress that has taken place in the treatment of disease generally, but this has not been sufficient to remove from us the terror that it has always caused. The tubercle bacillus takes the lead, by far, of all the microbes in its baneful influence, and there is not a race on earth but feels more or less its destruction. The virulence of many diseases is felt more at certain periods of life, but the tubercle bacillus finds a good soil at any stage. The period of infancy, childhood, adolescence, maturity, and the vigorous stage of life, have not the resisting power necessary to combat this king of germs.

One may not be particularly impressed by the importance of the serous membranes which in health command no unusual consideration; but let them become the seat of inflammation, and we have some of the most interesting diseases. This membrane is often to be reckoned with, particularly in the peritoneal, pleural, and cerebro-spinal cavities, and also in other parts of the body it offers much work for the clinician, and material for the pathologist. Of the three cavities mentioned, the most important is the cerebro-spinal, by virtue of its containing the brain, that organ which is superior to all others —the governor of the human economy. When the serous covering of this wonderful structure is inflamed, it so impairs the nerve tissue laying beneath it, that there is produced one of the most important diseases to which the cerebro-spinal system is liable.

Tubercular meningitis is often a part of a general tuberculosis, or secondary to infection in some other location. The organ that is most inflamed or filled with the deposit is the one that holds prominence and decides the clinical course of the disease. A tubercular deposit in the lungs or bronchial glands may exist for a long time and run a chronic course, and the symptoms be only those that would naturally arise from the absorption of material from the inflamed area; but let this same process begin at the base of the brain, and the clinical symptoms and course of the disease are materially changed. The symptoms are not so much due to the absorption of toxines as to the direct effect upon the nerves which have their origin in this location.

In the cases that I have observed there was complete obeyance of general symptoms to those arising from the brain. It often begins where the primary deposit is small, and not sufficient to give rise to any definite illness; therefore, tubercular meningitis may begin, apparently, as a primary affection.

My experience has been such that two stages of the disease could be well-defined with premonitory symptoms like peevishness, listlessness, headache, dizziness, anorexia and restless sleep.

I well remember a boy ten years of age who had been ill for two years with hip-joint disease. He had nearly recovered, was gaining flesh, developing rapidly in every way, and feeling so well that his studies were resumed with a private tutor. He showed rapid advancement and in fact was precocious as are most of these patients. His parents and tutor began to notice a lack in his accustomed vivacity and eagerness to learn, and he now and then suffered from headache,



nausea, anorexia, general malaise, slight fever, accelerated pulse, and restless nights. At the end of a week there was vomiting, severe headache, constipation, slow pulse, slow acting pupils, temperature 100, restlessness and awakening from apparent sleep and crying out as if terrified by some vision. A peculiar noise was made with the act of expiration; it was not a moan or a sigh exactly, though it made one think of both. These symptoms continued for a week when Cheyne-Stokes respiration, irregular pupils, convulsions and coma followed and in another week the patient succumbed. This patient had periods of improvement, like many others one sees when the course extends over a period of a few weeks. There were whole days where the condition, apparently, was so improved that it made one feel skeptical in regard to the diagnosis.

The infectious fevers, gastritis, and other forms of meningitis, require careful consideration in this connection. If we keep a few cardinal symptoms in mind, there will be no trouble in differentiating from the first two diseases mentioned, but there may be cases where it will be impossible to say which form of meningitis is present. These symptoms are, vomiting without apparent cause—the ejecta shoots out with force, without retching and with but little nausea—constipation, slow, irregular pulse, headache, and slow-acting pupils. With this condition present it should not be necessary to wait for the prominent symptoms of the next stage before arriving at a diagnosis.

It was my privilege some years ago to observe a case in a boy four years of age who had been sick a week and treated for gastritis. The most prominent symptom was the vomiting, which, by careful observation, was determined to be cerebral and due to changes going on at the base of the brain. The little rise of temperature, slow pulse and condition of the eyes were sufficient to confirm that the disease was meningitis of a tubercular nature. When this diagnosis was offered, it was promptly ridiculed; but in a few days Cheyne-Stokes respiration, ptosis, twitching, convulsions, then coma followed, which, in time, ended in death.

Severe cases of gastro-enteric, and other exhausting diseases, are attended with marked nervous symptoms and sometimes the hydrocephaloid state. During the past summer, several of my cases were sufficient to cause great anxiety in regard to the brain, as in these cases meningitis is at times a complication. A child of twenty months in the second week of an attack of entero-colitis kept either the head, the arm or the leg in constant motion, which alternated with stupor. I have thought that in such cases there was a slight effusion which disappeared as the patient grew stronger.

In reviewing the ailments of the human body, or the diseases caused by specific agents, one is impressed with the fact that the meninges are a frequent point of attack. Not only are they affected by contiguity, as from a suppurating ear or other pus area, but they are liable to become primarily or secondarily the seat of any of the micro-organisms. In other forms than the tubercular, the attack commences with more violent symptoms and runs a more acute

course. The cerebro-spinal, or epidemic form, may be prevalent at certain seasons of the year. The onset is abrupt, affects the brain and cord primarily, and runs a course like a general infectious disease.

In meningitis there is a serous exudation, sometimes clear, often cloudy, and containing lymph and pus. In the tubercular form, there are nodules which vary in size from a pin-head to a pea. When necessary to clear up any dispute in diagnosis, lumbar puncture may be made and the fluid examined microscopically, though this procedure may be more scientific than advantageous in the treatment of the patient.

The fact that tuberculosis exists in any form shows what imperfection there is in man's mode of living. It is possible that the human race may have sanitary laws some day that will stamp it out. Even with good soil we must have the bacillus or the disease will not develop. A predisposition to the disease is found in one who has delicate, pale skin, oval face, and long, thin bones. The enzymes in the tissue of a patient of this type are not able to destroy the enzymes formed by the tubercle bacillus.

Certain individuals seem to enjoy immunity from tuberculosis after suffering from an attack. I have observed several cases after tubercular ostitis, where the patient had been in an atmosphere ladened with the tubercle bacillus without being infected. I have been impressed with a neurotic tendency existing in children who have been victims of tubercular meningitis. It is often the case that an ancestor had epilepsy or some other affection indicating a neurotic condition. The age when the disease is most prevalent is between two and five years, when the brain is beginning to be active, when the child is developing rapidly and taking cognizance of its surroundings.

These patients are extremely sensitive to any noise, and therefore a room that is in a part of the house away from street noises or any other disturbance, large and well ventilated should be selected.

Clinicians generally agree that there is no treatment known that will save the life of the patient. We hear of one now and then who survives, but it is quite rare. As long as our efforts are fruitless, they should be directed in bringing to the patient as much comfort as possible. It would be bad practice to deny chloroform by inhalation to a case in convulsions, and other drugs of this nature are used with benefit in thoroughly nervous conditions. Food should be administered in small quantities and in a thoroughly concentrated form, especially when vomiting is frequent. Rectal feeding may be resorted to, for a day or two at a time, when necessary to rest the stomach. Special care should be exercised in the selection of a nurse. Here is a case whose nervousness depends upon a central cause, and it is very important to exclude all external irritation. A loud word or look of disapproval has a bad effect. A good nurse knows how small impressions influence the patient, and one who can adapt herself to her environment and anticipate the wants of the sufferer is indeed a blessing. (Applause.)



## DISCUSSION.

P. W. NEEFUS: There are two reasons, Mr. Chairman, why I should not discuss this paper at this time. One is lack of time, and the other is, not sufficient preparation. I should not give so hopeless a prognosis, however, as the doctor gives, as quite a number of these cases do recover, although they have some trace of the disease left, be it facial paralysis or what not; and one definite point of diagnosis the doctor has left out of his paper, which is the rigidity of the muscles of the neck, to distinguish it from a local fever, for instance. That is all I will detain you with.

J. T. SIMONSON: There are a few things I would like to speak about in the diagnosis. I think the difficulty in the diagnosis of meningitis can very frequently be overcome by the use of the Koenig symptom, that is by the rigidity of the muscles of the lower extremity when the thigh is flexed at right angles on the abdomen, and at the same time to attempt to extend the leg. I think it has been pretty well settled that in those diseases of the central nervous system, the brain, meningitis will give that sign very markedly on attempting to extend the leg when the thigh is flexed on the abdomen. The pressure will be resisted; the leg cannot be extended. That is one point that sometimes will aid a great deal in the diagnosis. And another little point I wished to speak of was the care that must be exercised in making a differential diagnosis between pneumonia and meningitis in very young children. The resemblance of a case of pneumonia to a meningitis is sometimes so strong, is so marked, that the case will be treated for some time, and very frequently a hopeless prognosis given; it will be treated as a meningitis, the chest will never be examined, and very valuable time is lost, when in fact the case is one of pneumonia. The meningeal symptoms of a beginning pneumonia in a young infant frequently simulate meningitis so closely that very great care is necessary to distinguish them.

PRESIDENT MOFFAT: I would like to add just one word to this, Mr. Chairman. I have been satisfied for some years past that if I make up my mind a disease is incurable, I cannot cure it, but it does not follow that nobody else can. (Applause.)

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## A CASE.

JULIA F. HAYWOOD, M. D.,
ROCHESTER.

On March 4th I was called to attend Mrs. S—— in confinement. I had previously examined her at different times and found on each examination a wrong presentation. I gave pulsatilla and waited,

hoping for a normal labor at the end of the pregnancy. On examining on the above date, I found dilatation, well advanced but the wrong position still existing. I sent for the nurse and waited until evening, when, as the patient was tearful, nervous and restless, I advised the use of forceps. It would have been a high delivery and attended with some difficulty, but during the manipulation necessary to adjusting the forceps, rotation occurred and descent was promptly accomplished. The forceps were then easily applied and delivery was accomplished without any apparent injury to either mother or child. These details are given at length as a sort of preface to what happened later with reference to the child. All went well for more than a week, with no complication of any kind save a slight disturbance with the breasts of the mother. This subsided in thirty (30) hours. The mother had had albumen in the urine for three months previous to confinement. The amount was not large, but sufficient to require care in diet, and some medical treatment.

About the tenth day I was called to see the baby—a fine, perfectly developed little girl, and while examining her she went into spasms. These it had had some twenty-four hours previous to my visit and were mild and general. These convulsive movements lasted, with but a few moments' intermission, all day and night, with a temperature of 100 deg. The next day, no change occurring, a consultation was held. Both the consulting physician and myself found albumen in small quantities in the urine of the baby. The temperature continued to rise and the urine grew less until about the tenth day, when the former reached a maximum of 104 deg. and the latter was entirely suppressed for thirty-six (36) hours. All this time the convulsions were almost continuous, the longest intermission being a period of three hours. They also became very severe, the agonizing struggles of the child being plainly audible down stairs. The parents wishing it, a third physician was called in at the time the temperature was highest and urine most scanty. This was about the twentieth day following birth, and this physician and myself continued in charge of the case until the end.

The child, during the intervals, took nourishment well and seemed conscious and normal in every way, save the scanty urine. This gradually increased in quantity, with also a gradual fall in temperature, but no cessation of the convulsions and no lessening of their frequency or violence. There was little, if any, meningeal effusion and no permanent paralysis, and no injury that was apparent. Day after day went by, with two nurses constantly in attendance, and no relief for the little sufferer.

About this time I suggested the use of a sedative, as carefully selected homœopathic remedies had failed to have any effect. Chloral, in small doses under similar conditions, had given favorable results, but this suggestion not meeting with favor from my colleague, other treatment was continued with practically no relief. The temperature remained at about 100 deg., and some paraplegia. The baby was about this time removed to the hospital in case an operation for the removal of any pressure upon the brain was deemed desirable. Pending this desperate resource the chloral treatment was given with the addition of bromide of soda; the chloral given in one-tenth of a grain and the bromide of soda in two-grain doses, in combination. This had a very happy effect in controlling the convulsions, these ceasing completely in forty-eight (48) hours. The paraplegia also disappeared and the baby seemed well on the way toward recovery. It did not thrive, however; the food disagreed, the child was extremely fretful and restless, and a marked degree of tympanitis occurred. The convulsions were kept nicely under control, and most of the sedative discontinued.



This condition lasted about two weeks, when the convulsions began again, but not severely. The urine had not been frequently tested at this time and my consultant thought there was no condition of the kidneys to warrant frequent examination. The child grew rapidly worse, the urine was again suppressed, and on May 11th the long and valiant fight was ended by the death of the child. Just before the end I secured a little urine by catheter, and the test then showed 50% albumen.

What was the cause of the convulsions? If the kidneys were at fault why should the convulsions have been quite as severe when a large amount of urine was excreted as when there was suppression? If traumatism from the use of the forceps had caused a hemorrhage, why had the child intervals of perfect brain function?

Besides, so little force was used to deliver that the child was not subject to more pressure than a normal labor produces.

Had the condition of the mother's kidneys any bearing upon the condition of the child's? Had also a fall which the mother received, any bearing upon this convulsive tendency, or were her efforts to produce a miscarriage productive of any injury to brain or spinal cord?

No autopsy was held, so the diagnosis at the end was still somewhat a matter of conjecture.

# REPORT

OF THE

# BUREAU OF SURGERY.



## THE DANGERS TO MODERN SURGERY.

SHIRLEY R. SNOW, M. D.,
ROCHESTER.

With the wonderful progress made in the world's history during the past quarter of a century, one would expect to find great improvement in the art of surgery. The rapidly multiplying population, with its ever-increasing tendency to mass the people together in large cities, with its attending dangers, has made great demands upon the physician to keep the mechanism in order to run at high pressure continuously. That our profession has met this demand and kept abreast of the times goes without saying. The perfecting of anæsthesia, the discovery of antiseptics, the Roentgen ray and the Trendelenburg posture have made possible procedures in surgery which had hitherto been beyond the surgeon's thought. It is well, then, with such a brilliant past and promising future, to rest a moment and, looking around, see what improvements can be made and what dangers are to be avoided. The dangers,so to speak, may be divided into two classes, those to the patient and those working against the interest of the surgeon himself. Among the former it is safe to say that anæsthesia forms the most formidable obstacle to an operation. The first question a patient asks is, "Doctor, do you think I can stand an anæsthetic?" and we must admit that there is a certain amount of propriety in this query. To lose one's self, even for a short time, is of no small matter, and the fact that there is that general dread shows that there is a certain amount of danger. The two prominent anæsthetics, chloroform and ether, have probably been brought to their highest point of perfection, so far as chemistry is concerned, consequently whatever improvement is made along this line must be made in the mode of administration. Surgeons will agree that the anæsthesia produces the greatest amount of anxiety in the majority of cases and the position of anæsthetist is of the



utmost importance. It is a strange condition of affairs, then, that we generally find the least experienced physician giving the anæsthetic. This is true in most, if not all, of our hospitals. Our colleges give little, if any, practical instruction in the administration of anæsthetics, consequently the man entering a hospital takes up the anæsthesia with a very scant knowledge of the subject. He serves six months, perhaps, as anæsthetist and then passes on just as he is beginning to learn how to administer the same. That it is a difficult, and at times, an unpleasant task cannot be denied. If better instructions were given in our colleges upon this subject, and our hospitals gave this work to an older interne, much would be done toward eliminating this danger from surgery. With this importance of the training of the anæsthetist how much greater is the importance that the operator himself should be well equipped before he undertakes the major operations. The brilliant success of a well performed operation, the apparent ease with which a skillful operator accomplishes his work. The lucidly misleading descriptions in the books all lead the uninitiated into the grave error that surgery is easy, and we find men of no experience undertaking operations which the experienced find difficult to perform. Emergency cases arise where a man is not only justified, but would be neglectful if he did not undertake an operation, but when it is possible to secure skill and experience it is little less than criminal for a man of no experience to jeopardize the life of his patient. Far be it from my purpose to restrict the practice of surgery. I believe there is no class of men more willing to show others than the surgeon. Our many well equipped hospitals offer abundant opportunity for one to fit himself for this work, while the Post Graduate Schools supplement this course, so that there is no excuse for a man undertaking this specialty without first placing himself where he is competent to operate. The harm done to surgery by an incompetent operator is hard to overestimate. A failure travels much faster than a success. The spirit that prompts an untrained hand must be of a pecuniary nature rather than to advance the interests of his profession.

It has been the custom to belittle the danger of an operation. This course reacts upon the surgeon as well as the patient. A capital operation should not be likened to the extraction of a tooth, while, on the other hand, a patient should not be diverted from a life saving procedure by overdrawing the danger. A careful diagnosis should be attempted in each case. It is not always possible to make a positive diagnosis, and the man who is candid enough to state the case frankly will, as a rule, not only retain the respect of his patient, but will also save himself from future embarrassment. One should have no difficulty in determining whether a case be medical or surgical, or as to the advisability of an operation, but in the end the patient must be the one to decide. The surgeon's position should be one of advising, not deciding.

One of the greatest dangers to modern surgery is procrastination. The difference in results produced by postponing an operation a day, a week, or a month cannot be calculated. Compare, if you will, the difference between an early and deferred operation for appendicitis.

Can you remove a cancer too early? And yet the majority of cases of cancer a surgeon sees are so advanced that it is impossible to eradicate the disease. It is the duty of the physician to warn his patient against the seemingly benign tumors if they are in a locality where cancer is prone to develop. There are cases of benign tumors which are dangerous in themselves and where delay brings complications. Who can tell at what time an ovarian cyst may rupture setting up a peritonitis; or a hernia become strangulated quickly, placing the patient beyond help? It was my intention not to cite any case to you to-day, but this one illustrates the point so well that I beg your indulgence: The patient, a woman fifty-seven years of age, a farmer's wife, which we know means hard work, noticed thirty-four years ago a slight swelling about the navel. This gradually developed into the condition shown in the photograph. Nothing was done until recently when she began having colic and called the attention of the physician to the growth. The operation showed the intestines firmly adherent to the larger pocket on the patient's right, while the other compartments were filled with tortuous coils of intestines. The original ring was about two inches in diameter. The case left the hospital at the end of five weeks with a normal abdomen, barring the scar.

Among the dangers to modern surgery we may mention the ease with which a patient may bring suit against the surgeon. It was the law that a lawyer could not take a case of this sort on shares, but since the code has been changed, the bars are let down and we have developed a class of lawyers looking for jobs on shares. Probably nine-tenths of malpractice suits come from injury to the bones. No matter how much skill or care may be given to the fracture, if it deviates in the least from the original it becomes, in the mind of the lawyer, a case for litigation or blood money. Consequently, the surgeon must be more cautious in trying to save a limb if he would avoid a lawsuit. An amputated limb tells no tales. But there is a better remedy than this: The courts hold that the only testimony competent to determine whether a result is good or bad, considering the accident, is that of some physician or surgeon in good standing. Consequently it behooves a man to look well into the case before he appears against his brother practitioner. If after examining the case carefully he should appear, let him remember that sooner or later he may have to face the same music. The profession must stand together, not to protect the negligent, but to see that there is fair play. There are two remedies which, I believe, would be of common benefit. First, the law should so read that no plantiff could bring suit before putting up a bond sufficient to cover the court cost if defeated. As it is now, the lawyer goes to his client something like this: "Allow me to take your case. If you win we will divide the profits; if you lose, it shall cost you nothing." It is a very simple story and little wonder that the injured jumps at the proposition. If he were obliged to secure the amount of the court cost, it would deter the worthless from bringing suit. In the second place, if a suit has been brought against a physician, it could be so managed that the merit of the case could be passed upon by a committee from the society to which the defendant belongs, and then other physicians should abide by that decision. This would be just to the plaintiff and defendant. The insurance companies which have taken up this work will accomplish much, but a united front from the profession will be of far more value in protecting the rights of the surgeon.



I cannot leave my subject without a word in regard to the general practitioner. But stop! Where is he? The oculist and aurist looks after his patients' sight and hearing. The laryngologist cares for his respiratory tract, the gynæcologist looks after those organs so productive of disease. The genito-urinary specialist sees that the male patient does not suffer for lack of care. The neurologist depends upon his nerve to vie with the skin specialist, while the surgeon stands aside willing to take anything that is left, even to Bright's disease. Nay, even after death the general practitioner is not alone with his patient, for then comes the pathologist to tell him what was the matter, and yet we are dependent upon the general practitioner. It is through his advice his patient seeks the specialist. He must bear part of the responsibility, and in case of a fatal result a good share of the censure. Many cases he has given his best thoughts for a long time and has only the account on the ledger as his recompense. When he brings his patient to the specialist he tells them that they must be ready to foot the bill, and they raise the money to meet the expense while the general practitioner's account is left in *statu quo*. I know I am on debatable ground. He cannot do the special work, hence should pass it on to the specialist, he should lay aside all thoughts of self, should be willing to see the specialist pocket the profit and smile. In other words, he must not be mercenary. A beautiful theory! Name a man in the practice of medicine who does not have use for money! His practice is probably his living. Therefore, there should be some equitable adjustment whereby both parties should receive their just dues. This arrangement will do away with much of the promiscuous operating spoken of above, and eliminate one of the great dangers to modern surgery. (Applause.)

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## PRELIMINARY LIGATION OF ARTERIES IN THE REMOVAL OF MALIGNANT GROWTHS.

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NEW YORK.

Any procedure which may be in the least helpful, or any experience which sheds whatsoever little light upon that dread scourge of mankind known as cancer, will, I am sure, be welcomed by the medical

profession, notwithstanding the many promising hopes which have been held out for its cure or eradication, in spite of the inspirations of earnest workers in the domain of modern pathology who oftentimes find the solution of the vexed problem almost within their grasp, nevertheless, cancer is to-day the worst plague of civilized life. While preventive medicine, quarantine, and a better understanding of the laws of health have done so much to mitigate disease and rob it of some of its terrors, statistics show that notwithstanding advanced science and higher thought cancer is on the increase.

Modern medicine is confounded, watches weakly at its progress and destruction, but lives in the hope that the next decade at least will bring forth relief. So it is that drugs, serums, therapeutic application of bacteria or their modified products—organo-therapy—each in its turn has had its day, some possessing apparent effects, but all, more or less, soon to be relegated to past and unprofitable experience. In the long list only the knife and caustic agents hold out any promise of a cure.

Cancer is a growth originating in epithelium and characterized by continuous and more or less rapid growth, which, invading the lymphatics, spreads to neighboring organs. Under certain favorable circumstances the growth is very rapid, the involvement considerable and toxemia an early symptom. When recurrence takes place after operation it is due perhaps to some cells left behind, insufficient eradication of the primary focus and of adjacent infected areas. More careful and radical surgery which contemplates extensive dissection into healthy tissue shows fewer or at least longer deferred recurrences. The actual cautery, chemical caustics, and X-Ray show oftentimes good results, for the reason that if infiltration has not taken place beyond the point of primary focus the mouths of the lymphatics are sealed by the scar, which, when it separates, leaves a clean and often uninfected base of granulating tissue. The itinerant or advertising "Cancer Specialist" has by such means often accomplished more than his scientific medical brother. From the standpoint of general surgery the early and complete removal of the part affected, including, where possible, an amount of healthy tissue, and the rendering the remaining adjacent parts unfit for a recurrence of the growth is our present purpose. Some years ago the writer became convinced that nature had many resources for gradual restoration of circulation in parts where main blood channels had been ligated. This was shown in a case of recurrent carcinoma of the breast. The recurrence was mainly in the axilla. It became necessary not only to ligate the lower large arterial branches, but also resect the axillary vein, which became very intimately involved in the secondary process. The condition of pronounced œdema which followed was somewhat alarming, but equilibrium of circulation was re-established, the patent made a good recovery and lived some years afterwards.

Some time after that a case of epithelioma of the tongue came into my service at the Metropolitan Hospital. The growth occupied principally the left side and anterior portion of the tongue. In this



case it was decided to make a preliminary tracheotomy, a careful procedure at times no doubt, but unnecessary and unsurgical, in my opinion. It was further decided to ligate the lingual arteries, assuming that would sufficiently control the circulation, then through a Whitehead gag the tongue could be cut off with a scissors, a few stitches placed in the stump to approximate the cut edges and the operation be complete. The linguals were ligated easily enough, they were recognized by several members of the attending staff who happened to be present. The tongue was removed as per programme with practically no loss of blood at that time. All went well until the patient began to recover from the anæsthetic, when a severe vomiting spell produced a hemorrhage through the mouth. The house surgeon and his assistants were unable to control the flow of blood and the patient succumbed. Post-mortem examination showed proper deligation of the linguals but an accessary branch at the root of the tongue, evidently from another source, produced the fatal hemorrhage. This case very thoroughly impressed me with the idea that ligation of linguals was not a certain procedure and reference to medical literature showed that this unfortunate accident, as above described, had happened in several instances. The next case of this character was one of sarcoma of the left superior maxilla, involving the eye and the hard palate on that side. The patient was a man aged about 50 years, who had been affected about one year. External examination showed that the disease was deep-seated, and to accomplish anything of value the operation must be decidedly radical. One of the troublesome features of such a case is, of course, hemorrhage, which not only obscures the field of operation, but endangers the life of the patient by strangulation if the blood enters the trachea, or if he escapes that calamity to run great risk from the subsequent development of an aspiration pneumonia from the septic clots. Accordingly, the common carotid artery or the affected side was ligated. An incision was made from near the external angular process of the orbit to the inner canthus of the eye, thence along the nose around the nostril through the furrow of the upper lip. This flap was dissected back and the bony growth exposed. With a chisel and heavy forceps the articulations were severed, leaving the division of the hard and soft palates until the last. There was very little hemorrhage, some oozing was promptly stopped by the application of the actual cautery and then packing with gauze. Great care was exercised lest any blood should enter the larynx. This was avoided by the use of the Trendelenburg position and careful sponging. Partial anæsthesia is the rule in such cases. There is a nice point between loss of pain and the continued presence of sufficient reflex to enable the patient to cough. This is the sanctioned surgical procedure in operations about the face, tongue and jaws.

This patient did well, the large cavernous wound granulated nicely, but as the disease had involved the brain through the base of the skull we were unable to determine whether his death some months later was due to shutting off the circulation by ligation of the

common carotid or to the effect of the primary disease. This vessel has been frequently ligated, and so far as is known, without bad results, but there is a strong probability of cerebral softening following the interruption of the blood current. Crile (Annals of Surgery) reports nineteen operations about the face, tongue, jaws, neck, where in the majority of instances both common carotids were temporarily ligated for forty-eight hours. This is accomplished by a small clip with parallel blade covered with rubber tubing regulated by a set screw. The trunk of the artery is isolated, one blade of the clip is slipped under the vessel and by means of the screw the blades are approximated until the blood stream is checked, but no damage done to the coats of the artery. This procedure answered the purpose that Crile intended; that is, making a bloodless operation. According to J. B. Murphy's clinical experience and observations on animals have shown that if the vessel be included with a plug of gauze in a large silk temporary ligature, with only sufficient pressure to stay the blood current and not fracture the interior, there will be no danger of thrombosis and much to be preferred to permanent ligation.

A case of recurrent carcinoma of the eyelid came next into my hands. This patient, a woman about 68 years old, had been operated on by Prof. Knapp and now presented enlarged endurated glands in the cheek and neck. In this case it occurred to me to ligate the external carotid artery on the affected side. The glands were removed and the operation practically bloodless, was very satisfactory. At this time I was unaware of Dawbarn's experiments along the same line, so that portion of the operation was done on independent lines. After my experience with this case I became acquainted with Dr. Dawbarn's method of starvation in malignant growths, which was to tie off the large arteries, then resect them and allow the parts to slough. The resection of the artery became necessary because he found that collateral circulation was very quickly established. He advised great care in these operations, to handle the veins as little as possible so as not to promote the formation of clots in them, to avoid dividing them so that the circulation away from the part would be sufficient to produce decided local anæmia.

Another case of "epithelioma" of the tongue came under my observation and was presented at Flower Hospital on "Alumni Day". The patient, a man aged about 55, had tuberculosis pulmonalis as well. In this instance I proposed to modify Dawbarn's procedure; that is, to ligate the external carotids, not resect them, but remove the tongue. Accordingly, chloroform and oxygen were administered, if not the right then the left ex. carotid was ligatured with silk, gag inserted, two teeth drawn so as to get at the attachments to the interior maxilla, and about two-thirds of the tongue cut off with scissors. This is done with the hand lowered and under partial anæthesia; practically bloodless operation. The tongue was sutured with some heavy silk sutures to minimize the granulatory space, one ligature left long and tied over the ear to prevent the tongue



from falling back in the throat and producing asphyxiation. The wounds in the neck were then closed with interrupted sutures and the patient put to bed. It might be pardonable here to state merely to show what can be done with a fair practical knowledge of anatomy and occasion for haste. The time was limited and it was necessary to complete the operation as quickly as consistent with safety to the patient and I was informed afterwards that the actual working time was eighteen minutes in this case. That is ligation of both carotids, removal and suture of the tongue and approximation of the wounds in the neck, apparently reckless haste. This patient made a good recovery and was doing well when I saw him two months ago. This last case demonstrated that both carotids could be ligated and the tongue removed, that the operation was both easy and satisfactory. It remained now for another opportunity to ligate and resect the artery and then remove the offending parts. This opportunity came with an invitation from my confrere, Dr. E. G. Tuttle, to assist him in a case of epitheloma of the tongue operation last June. This patient was a male about 52 years of age, growth occupied about one-third of the distal end of the right side of the tongue. Briefly, both external carotids were secured with double ligatures and the arteries cut between and allowed to retract, then the tongue was removed and the stump carefully sutured. Patient bore operation very well, it was practically bloodless and he spoke to us within an hour after the operation. A small slough appeared on the stump of the tongue on the affected side which came away and microscropical examination showed it free from cancer elements, and now after four months Dr. Tuttle tells me there is no sign of return, the man can speak and he is in every way satisfied with the result. This last I beg to offer as the culmination of the previous experiences above related. I believe it to be the procedure for malignant disease of the tongue, jaws or face. It can be made thorough, can be done quickly or leisurely, there is practically no danger from aspiration of blood into the trachea and the growth is thoroughly removed and whatever benefit is to be derived from the starvation process, it is applied to adjacent tissues which, of course, are to an extent always more or less infected, and the subsequent slough should leave an almost healthy base. My plan is to prepare these cases carefully, have the teeth polished, tartar removed, mouth rinsed frequently with antiseptic and deodorizing solutions and so prevent the development of bacteria in the mouth. All nourishment should be given by the rectum several days before the operation. (Applause.)

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## DISCUSSION.

PRESIDENT MOFFAT: I would like to state that I have been so fortunate as to see Dr. Honan operate. He spoke of reckless haste. There was no appearance of haste at all.

J. H. SCHALL: I would like to ask Dr. Honan what he would do in case of cancer of the lower jaw?

W. F. HONAN: The operation of ligation of the external carotids may be performed in any operation, particularly for the removal of malignant disease about the face, jaws, tongue, palate and upper part of the neck. It serves a manifold purpose, bloodless operation, avoids the risk of an aspiration of blood clots into the trachea in cases involving any part of the mouth, and most important of all interferes with nutrition of parts affected as well as surrounding tissues.

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# THE TREATMENT OF A FEW POST-OPERATIVE CONDITIONS.

GEORGE T. MOSELEY, M. D.,
BUFFALO.

To my mind, the practical value of a paper upon a medical or surgical topic depends directly upon the extent to which it represents the personal experience and observations of the writer. And there are two chief vantage points of observation of the various post-operative conditions, one that of the surgeon or nurse in charge, and the other, and no less important one, that of the patient.

It is comparatively seldom that a surgeon enjoys the privilege of observing the after effects of a laparotomy from the other end of the knife; and having lately experienced that pleasure, and having made several observations from the point of view of the victim, which have since been of value in mitigating the suffering of my own patients, I will, with your permission, report a few to this Society. While some of these points may appear trivial, as not implying a matter of life or death, I assume that nothing is trivial which aims to relieve suffering, or to diminish the discomfort following a serious operation. As surgeons, we are obliged to inflict so much pain upon our fellow creatures, that we should be constantly alert to prevent all unnecessary suffering; and anything tending in that direction merits our earnest consideration.

It has been my experience, and the testimony of many patients confirms the view, that the suffering following abdominal operations comes not nearly so much from the injury done to sensitive tissues, as from reflex or accompanying disturbances; and of these, the most annoying are the intolerable thirst, the nausea and vomiting, and colic from incarcerated flatus in the intestinal canal. If these three factors can be eliminated, the post-operative period will at once be robbed of nine-tenths of its distress; and by a few timely precautions, I believe this may be accomplished in a large majority of cases.



In former times, when major operations were regarded much more seriously than at present, a week or two were usually spent in preparing the patient for the ordeal. With the improvement in our surgical and aseptic technique, much of this treatment was found to be unnecessary, and the swing of the pendulum has brought many of our surgeons to the point of taking their cases in off the street, sterilizing the field of action, and opening the abdomen without further ado. Of course a solid meal is omitted before anæsthetizing, but other precautions are, by many of our best surgeons, deemed superfluous. I believe that to this lack of preparation are due the distressing symptoms which I have mentioned, viz., thirst, nausea and colic.

A word as to the causation of the intestinal colic following abdominal work, will indicate the means of relief. Any injury or irritation of the sympathetic plexuses, from exposure and manipulation of the viscera, results in a depression of the normal nerve tonus of the intestine, partial paresis of the muscle of the bowel, stasis of its contents, fermentation, with production of large quantities of gas in the relaxed coils of intestine, inability to expel it, hence incarceration of the flatus, with the atrocious pain which that implies.

The rationale of its prevention consists in dieting the candidate for laparotomy strictly for forty-eight hours preceding it, by cutting out all starches, sugars and fermentable articles, allowing only foods easily and entirely assimilable. Free the entire alimentary tract of its former contents by a brisk acting purge, preferably one which acts on the liver, increasing the secretion of bile, and which leaves the bowel in an alkaline condition favorable to digestion. For this purpose I know of nothing better than Kutnow's Powder, given in one to two dram doses, on rising, in a glass of hot water, followed by a glass of plain hot water. This will produce a thorough evacuation of solid, liquid and gaseous contents of the bowel in a few hours, without the slightest griping, and should be repeated daily during the two or three days of preparation. I also give during this time a dose of nux vomica before meals, with some reliable intestinal antiseptic, preferably salol or beta-naphtol. Having thus freed the intestinal tract of its fermentable contents, and put it in as antiseptic condition as possible, it is only necessary to cleanse the lower bowel by a copious enema before operating; and if this empty, clean intestine be then kept empty for the subsequent two or three days, the colic will be eliminated from the patient's list of woes.

In cases of emergency, where no preparation has been possible, and flatulence and colic appear, I resort at once to a full dose of Kutnow's powder or citrate of magnesia, at the same time unloading the lower bowel by a high up enema of glycerin, turpentine and hot water. A hypodermic of strychnin aids materially in toning up the bowel muscle, thus favoring expulsion of gas, and preventing incarceration of flatus in distended loops of paralyzed intestine. While waiting for the action of these measures, a large amount of relief may be afforded by the use of the Paquelin cautery; making

strokes or passes in every direction over the abdomen, with the point a fraction of an inch away, never actually touching the skin.

Of the nausea and vomiting which we meet so universally following the use of anæsthesia, I believe the predisposing causes to be a relaxed and irritable condition of the stomach, a condition of hepatic torpor, and the presence of food or bile in the stomach or upper part of the small intestine. To prevent it, I should tone up the stomach with nux vomica for several days as previously mentioned, give small repeated doses of calomel until the liver is acted upon, and omit the liquid nourishment ordinarily given in place of breakfast the morning of the operation; so the patient comes to the table with the stomach perfectly empty. It is then kept empty for forty-eight hours, and the nausea is reduced to the minimum, and the vomiting usually to a single emesis as the patient is coming out from anæsthesia. Where this preparation has been impossible, and nausea and vomiting occur persistently, I have found great relief from lavage through a stomach tube, with water as hot as can be comfortably borne; followed, if necessary, by sips of iced champagne, or oxalate of cerium, five grains, dry on the tongue.

Now if such a plan of preparatory treatment be followed, and the stomach kept empty for forty-eight hours, one might reasonably expect the thirst to be intense; for the preliminary purgation, hemorrhage during the operation, diaphoresis and diuresis combine to remove fluid from the system, which will clamor persistently for its replacement. I believe I have discovered a plan which will obviate this thirst in every instance, and make it not only possible but easy for the patient to go forty-eight hours or longer without water. It is simply to completely saturate the system with water for twenty-four hours preceding the operation, drinking freely every hour or two, whether thirsty or not, up to within two or three hours of the time for the anæsthesia. For the efficacy of this scheme I can vouch, both from my own personal experience and from that of a number of patients, upon whom it has been tried with marked success.

In the treatment of hemorrhage and shock I have but one idea to add to our ordinary treatment, and that is the use of supra-renal extract in both conditions. For the troublesome capillary oozing which often occurs deep in the pelvis after enucleation of closely adherent tumors, where dense adhesions have been broken up, the adrenalin solution of P. D. & Co. is singularly effective in contracting the vessels and controlling the hemorrhage until a permanent clot has formed; obviating the necessity for a drain.

In shock, I have seen the supra-renal extract in five-grain doses save life when every other measure had failed. I recall several cases where the shock following prolonged and extensive abdominal work was most severe, and the patient seemed on the point of slipping away, in spite of the most energetic use of heat, oxygen, stimulants, saline infusion and hypodermics of nitroglycerin, atropin and strychnin to the limit of safety. As a last resort the supra-renal extract was administered in five grain doses, with most prompt effect, and the result of saving the life of the patient.



I spoke a moment ago of pushing atropin and strychnin to the limit of safety, and you will pardon me if I digress a moment to utter a word of warning regarding the too free use of strychnin in shock. It has been my unfortunate experience to see two valuable lives sacrificed to the undue zeal of the nurse or surgical assistant in injecting strychnin to combat shock, repeated doses being given until the cumulative effect stopped the heart in systole as the shock disappeared. It must be remembered that in this condition of cardiac and vascular depression, the circulation is so feeble that remedies act very slowly even when introduced directly into the circulation. And as we fail to obtain the ordinary physiological effect, the temptation to increase and repeat the dose is, in these desperate cases, very great. But it is in just these cases that the action of any drug becomes cumulative, and it is most painful to see the case just rescued from profound collapse, succumb to strychnin poisoning as the circulation begins to regain its force. In such cases it is better not to venture beyond the safety line with drugs like strychnin, which, while one of the best heart tonics, may so easily be fatal in an overdose. The logical plan, therefore, is to change or rotate remedies, when one fails to produce the desired result; and when other means fail to relieve shock, the supra-renal extract should always be tried, as by its use the lives of persons apparently moribund have been saved.

A condition which one occasionally meets in hospital practice, and one which may prove fatal, is the delirium tremens following accidents or operations in old alcoholics. In several of these cases, where the danger seemed imminent, I have had beautiful results from an intravenous infusion of normal salt solution, after a very profuse bleeding. When the blood is surcharged with a toxic substance, of which the system is unable to rid itself, and untoward effects are being produced thereby, the quickest and surest way of removing a definite quantity of such toxin is to remove the quantity of blood which holds it in solution. And if this blood be immediately replaced by an equal or even greater quantity of salt solution, no bad results ensue and the relief is prompt and permanent. It may be remarked that this is a reversion to the treatment of our ancestors, but I am not advising it as an antiphlogistic remedy in inflamatory disorders, but as an emergency treatment, to remove a poison which is overwhelming the system and paralyzing the nerve centers—a makeshift to give the system an opportunity to readjust itself and renew the fight against fewer odds.

This same plan of treatment, viz., profuse blood letting followed by immediate copious infusion, appears to me to be the most rational procedure in that terribly fatal condition, post-operative uræmia. I can say nothing positively of its efficacy, having used it in but one case—and that one terminated fatally; but I believe my error then was in abstracting too little blood, and in the next case I intend to remove enough, even if I have to replace it from my own veins.

I will close by requesting a comparison of observations upon post-operative uræmia. My own lead to the belief that the symptoms are

caused by a cerebral œdema, due to the accumulation in the blood of certain toxins related to the group of nucleins or albumoses, such substances being produced or increased by the inhibitory effect of the anæsthetic or operation, or both, upon the normal metabolism—the oxidation and elimination of waste products. I have seen cases of chronic nephritis live for weeks with the daily elimination of urea less than one-fourth normal, and I have seen a patient succumb to post-operative uræmia, with the quantity of urea up to the time of death never less than one-half normal. Altogether there seems to me to be a radical difference between the uræmia following anæsthesia and that coming in the ordinary course of chronic nephritis; not only in its symptoms and course, but in its amenability to treatment. The purgation, diaphoresis and saline infusion which are so potent in the uræmia of nephritis, seem utterly inadequate in the post-operative variety, even where the renal condition has not appeared so serious from prior urinalyses. The course of the condition is more virulent and more rapidly fatal.

Our present knowledge of this complication is meagre, out of all proportion to its importance, and I beg to suggest that in every case of uræmia after operation frequent complete urinalyses be made, particularly noting the presence and character of abnormal albuminous substances, that we may determine, if possible, its precise etiology, and thus more frequently prevent its fatal termination. (Applause.)

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## DISCUSSION.

PRESIDENT MOFFAT: The paper is before you for discussion, gentlemen. At the beginning of the year I announced that I was in hopes that at the meetings of this homœopathic society we could study homœopathy; that the specialists in each line, surgery, therapeutics, etc., would try to show us the difference between the homœopath and the man who is not a homœopath. If I am an oculist, why should I expect my fellow members to send a patient to me instead of to an allopathic oculist? You are a surgeon, why should I send my patients to you instead of to an allopathic surgeon? I would ask Dr. Moseley, is homœopathy any help in post-operative surgical cases? Has he found by experience that our medicines do not work so satisfactorily as, or are not necessary with, the procedures he here advocates? Is this the experience of others? That is what we come here to learn.

H. C. ALLEN: *Mr. President*, I have had a little experience in the last few years in which, with my partner, Dr. C. E. Fisher, we have been driven sometimes almost to the wall with cases of post-operative vomiting, the nausea and vomiting of post-operative surgery; and in the last year we have found a means, we think, of practically relieving it with a homœopathic remedy. I think now for the last fifteen or twenty operations we have not had a single case of vomiting. Previous to that we had some that ran two, three or four days



in spite of anything we could do. Give a dose of the constitutional homœopathic remedy, the similimum, twelve to twenty-four hours before operation, and you will rarely see post-operative vomiting.

G. T. MOSELEY: Pardon me, doctor, will you repeat those last two sentences?

H. C. ALLEN: Give a dose of the homœopathic—"similia" if you like—similar remedy, constitutional remedy, twelve or twenty-four hours before operation, and you will rarely have a case of post-operative vomiting on your hands. It may be Sulphur, Calcarea, Silicea, Thuja, Psorinum, Tuberculin, or any constitutional remedy that applies to the patient. This is our practical experience. I suggest it to the members of the Society for trial; but you must give—at least I found it necessary to give—a strong potency.

J. H. SCHALL: How about the action of the salol on the kidneys, combined with the irritating action of the ether? It is a well known fact that chloroform has almost as irritating an effect on the kidneys as ether has. That has been demonstrated again and again. While in one of the hospitals in New York I kept a record for nearly two years, of the urinary examinations, and a certain number of them had albumin after anæsthetizing, whether it was chloroform, ether or oxygenated chloroform. Now, we all know that salol has a certain irritating action on the kidneys. In combination with the anæsthetic would that not invite uræmia, some kidney complication?

G. F. LAIDLAW: *Mr. President*, I am not a surgeon, but I know something about uræmia. The kidney is an extremely sensitive thing, and some people's kidneys are more sensitive than others. In regard to the question of salol, it splits up in the body into salicylic and carbolic acid. I can say positively that salol will produce albuminuria and uræmia; not in every case, but in certain cases. In two cases I have found it to produce a distinct albuminuria and marked uræmic symptoms; not following operation, but in disease. I have known small doses of arsenic to do the same thing. Chloroform and ether, almost all volatile drugs, irritate the kidney. In fact, there is scarcely a drug in the materia medica which will not produce either albuminuria or glycosuria, or both. The kidney, being the main highway of excretion, is affected by nearly everything that you put into the mouth or inhale into the lung. It is one of our most sensitive organs. On the question of uræmia after operation, I think, at present, our light is not very brilliant. There comes in the question of anæmia. Why are anæmics much more subject to uræmia than others? When the hemaglobin is below 40% you will almost invariably get post-operative uræmia. In the American Medical Society a year ago, Dr. Wyeth (I think) took the position that no operation was justifiable on a patient having hemaglobin under 40%, on account of this danger. I have recently seen the case of a patient, who died about a week ago of acute uræmia, following an operation on the kidney, in which I had examined the blood four weeks before the operation, and found the hemagolbin 40%, and a week before operation, 35%. Naturally, in my report, I mentioned the danger of anæsthesia in the case; but the X-ray

having shown a calculus in the kidney, and as the man was practically dying from sepsis, it was decided to take the risk. In forty-eight hours the man was dead with acute uræmia. He had albuminuria and well-developed nephritis. I got some light on that question from Dr. Edebohls through his operation for Bright's disease, with which you are all familiar. Some six months ago I saw the doctor operate by his method on a case of nephritis; and I noticed that he used ether in the operation. As he was operating on Bright's cases, I asked Dr. Edebohls his opinion of the use of ether in nephritis. He said that he had found that the bleeding of the kidney attendant upon an operation upon the kidney relieved the congestion; so that he did not fear the increased congestion caused by the ether. That would apply to an operation on the kidney itself. That was the opinion of a man who had operated on quite a series of cases of Bright's disease, and, I believe, one who is able to judge. At the same time, as a man who handles kidneys, I am much afraid of an anæsthetic; not only in albuminurias, but in cases of congestion of the kidney and where the urinary solids are persistently low. They are dangerous cases to handle, and, more especially, if you have an attendant anæmia. Sometimes the most promising cases, as we who make urinary analyses frequently see, sometimes after the simplest operation on an extremely anæmic patient, and especially in albuminuric cases, life will go out like lightning; and when the danger starts, except to trust in Providence, I really know of no method to carry the patient through. (Applause.)

G. T. MOSELEY: I was asked a question by the president regarding the homœopathic treatment of these conditions. In reply to that question I would say that I had not the face to get up and tell this Society that which it knows very much better than I. I assume that the various members of the Society know more about homœopathic indications for drugs than I do, and if they do not know it, there are materia medicas where they can look for symptoms, and I should not have the audacity to get up here and give the indications for a large variety of homœopathic remedies for nausea following operation. I simply wished to make a few points which were to some extent different from the ordinary treatment of many surgeons in these conditions, and which I found of value in my own personal experience. My idea is that the value of a paper on the treatment of any condition depends upon the extent to which it embodies the personal experience of the writer, and therefore is not valuable to the extent to which a man gives indications of homœopathic remedies taken bodily out of the materia medica. Anybody can study the materia medica and get the information for himself. (Applause.) Now, as regards Dr. Allen's remarks on the treatment of nausea following operation, I would say that it simply goes to show how the experience of two men can be radically different. I will admit that I never in my life have given the constitutional remedy to a patient before an operation to overcome nausea. I may say also that I have a very good friend in Buffalo who is, I believe, as careful a homœopathic prescriber as it has been my lot ever to meet, and in a large series of cases upon which I have operated for him, he has carefully given the remedy, the constitutional remedy, before operation, on the ground and with the belief that it would stimulate repair in the wound, that it would lessen the liability to infection, etc., and in none of those cases have I ever seen any difference in regard to the amount of nausea following the operation. Now, as regards salol, I will further state that I have been very careful in the use of salol. I should not use it where there was any albuminuria or casts in the urine. There are plenty of other antiseptics that can be used as well; as regards the condition of uræmia following operation, my observation has been that post-operative uræmia is a condition which differs very materially from that which occurs in common practice, not only in its symptoms and course of the disease, but in its treatment. The same treatment which we find so potent in the uræmia of Bright's disease is utterly inadequate in the treatment of a post-operative case, and I would suggest that in every case of that character repeated urinalysis be made at frequent intervals, particularly noting the presence (and character) of the albuminoid bodies, to determine, if possible, the exact etiology of that condition whereby we can prevent more frequently its fatal termination. (Applause.)



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# REPORT

OF THE

## BUREAU OF LARYNGOLOGY AND RHINOLOGY.

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## THE TONSILS.

FREDERICK D. LEWIS, M. D.,
BUFFALO.

It seems to me that the value of a paper presented before a society of this nature, is in the personal experience, results obtained and the deductions of the author. It is my purpose, therefore, to avoid all reference to the anatomy, physiology or histology of the tonsils, and such matter as can be obtained from text books or medical journals, and to dwell more particularly on the importance of the recognition of disease of the parts and the importance of their

removal. The tonsils, so far as I can learn, are of no value at the present time in the economy. There was, I presume, a time when man lived on roots, and uncooked rough foods, that the thick mucilaginous secretion covering the rough edges protected the throat from injury; but now that our food consists of cooked and soft substances their sphere of usefulness is gone. The tonsils are glands, containing a number of secreting cavities, that should be below the surface in a healthy state, so that on inspection they should not be seen. Enlargement of the tonsils is the result of the closure of the mouths of the cavities, and as the secretion continues there is an enlargement in the direction of the least resistance. If this condition is continued or frequently repeated then results the development of connective tissue and a permanent hypertrophy. The retention in the cavities results shortly in the decomposition of the fluid which is changed from a transparent fluid to a thick yellow foul smelling matter, which is an ideal culture medium for various bacteria. This decomposed secretion is being poured out into the throat and taken into the stomach with each swallowing. The result can easily be conceived, the owner of the tonsils is having the digestion interfered with and the whole system is being slowly poisoned.

What shall we do to remedy this condition of hypertrophied tonsils? In answer I would say that all the physician can do in any case is to assist nature and follow her methods. Nature, in her efforts to rid herself of an offending organ, sets up on the slightest excuse a tonsilitis or as frequently termed, a quinsy sore throat This results in some destruction of tissue and the process is repeated at varying intervals until there has been enough of the organ destroyed, so that it is no more offending when the attacks of quinsy cease. Nature usually takes about fifteen or more years to accomplish this work, and in the meantime there may be ear complications established from the throat pressure that will be very difficult, if not impossible to correct. With the tonsilitome a few seconds will produce the result of years of nature's efforts. The object of all this argument is to more forcibly impress the advisability of removal of tonsils wherever they are found hypertrophied, whether there is evident trouble from them or not. The operation is a comparatively safe one; the number of fatalities in the whole country for the last ten years would make a small number, probably not one in a thousand cases operated. I have had some shock, fever or severe hemorrhage in a few cases, but never a loss of a life and the results are such that in six months, the child would, as a rule, not be known as the same; the appetite increases, the food is properly taken care of, the weight, color and energy are improved. With regard to grown people repeated attacks of tonsilitis are at once checked. In instance of the last I was called about a year ago to attend one of the Pan-American visitors to our city who told me she had frequent attacks of ulcerated sore throat which usually confined her to the house for two weeks. I was fortunately able to control the attack then in one week, but advised her when she returned home, her home was in New York city, to have the tonsils excised. She wrote



me on her return requesting me to come and operate her. This was done last February and a letter from her a few days ago reported a comfortable condition and no sore throat since the operation. One of the most frequent inquiries that the operator will be asked is, will not the removal of tonsils affect the voice? I always answer yes, but it will be in the line of betterment. I usually illustrate this to my patients by telling them that the voice may be compared to a wind instrument and should two great obstructions be placed in such an instrument the sound waves must be interrupted and the tone not so clear. In the consideration of the tonsils the impression is at once the faucial tonsils which are located in either side of the throat. There is, however, an extension of the same nature of tissue into the vault of the pharynx, known as the pharyngeal tonsil, or more generally termed adenoids. The necessity for the treatment of adenoids has been so frequently and thoroughly written about that I will make no reference to the subject here, beyond the fact that even small masses, that did not at all interfere with the breathing, have been removed by me with great benefit to the patient. I think the reason was that the perverted secretion had affected the general health. There is another mass of tonsillar tissue at the base of the tongue, which completes the ring, that is of great importance. The past year, for some reason, has been rich in cases coming with about the following complaints; my throat feels always full, or as they generally describe it, flannelly, and there is a constant desire to swallow; there is no cough, but the secretion is thick and stringy; sometimes there is an occasional spasmodic closure of the throat for a few seconds. In those cases I always expect to find a thickened condition of the lingual tonsil. These conditions I treat by reducing the hypertrophy by applications of trichloracetic acid; sometimes one application is sufficient, but usually several are required.

These few remarks cover pretty much all I wish to say and I only hope they may be conductive of a good discussion as I have tried to be brief and rather suggest than complete thought. (Applause.)

# REPORT

OF THE

BUREAU OF MATERIA MEDICA.

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## THE APPLICATION OF HAHNEMANN'S PSORIC THEORY IN THE TREATMENT OF ACUTE DISEASES.—PSORINUM THE GREAT ANTIPSORIC.

H. C. ALLEN, M. D.,
CHICAGO, ILL.

Hahnemann did not include this great polychrest in his chronic diseases, for the reason, as he says: "That its effects upon the healthy organism have not been sufficiently ascertained. * * * I call psorinum a homœopathic anti-psoric, because if the preparations (potentization) of psorinum did not alter its nature to that of a homœopathic remedy, it never could have any effect upon an organism already tainted with that same identical virus. The psoric virus, by undergoing the process of trituration and succession, becomes just as much altered in its nature as gold does, the potencies of which are not inert substances in the human economy, but powerfully acting agents."

Subsequently, Hahnemann and his colleagues made a careful proving of psorinum, using potencies made from the sero-purulent matter contained in the scabies vesicle. A salt from the product of psora was used by Hering and his American provers. This is not a so-called isopathic remedy, in fact Hahnemann contends there is no such thing in homœopathic practice as isopathy, for he says: "Psorinum is a similimum of the itch virus. There is no intermediate degree between idem (isopathy) and similimum; in other words, the thinking man sees that similimum is the medium between simile and idem. The only definite meaning which the terms 'isopathy and æquale' can convey, is that of similimum; they are not idem."

One of the obstacles which confronted Hahnemann in the development of the science of therapeutics was the tendency of many acute diseases to return after an apparent recovery, or to relapse after a partial improvement. This it was that set Hahnemann at work in search of a cause for many of his imperfect cures and finally resulted in his theory of chronic diseases and his antipsoric remedies. Of this he says, Organon, § 80:

> I spent twelve years in investigating the source of this incredibly large number of chronic affections, in ascertaining and collecting certain proof of this great truth, which had remained unknown to all former or contemporary observers, and in discovering at the same time the principal remedies which are nearly a match for this thousand-headed monster of disease in all its different forms. Before I had obtained this knowledge I could only teach how to treat the whole number of chronic disease as isolated, individual maladies, * * just like an idiopathic disease:

For many years I failed to relieve or cure many chronic diseases, because I regarded them and treated them as "idiopathic diseases"; and because I had never put Hahnemann's theory of chronic diseases to the test of actual practice, hence did not believe in its truth or its practical worth. I also failed to realize that without one month of close study or careful investigation, I pretended to know more of the cause and nature of chronic diseases than Hahnemann—the ablest observer in the history of medicine—did after he had studied this subject twelve years. Now, after twenty-five years of labor in the treatment of all forms of chronic diseases, I am prepared to verify the truth of every statement made by Hahnemann in his theory and treatment of these numerous, annoying, persistent and often incurable ailments. Perhaps some of my colleagues may be in the same anomalous position of disputing the truth of a verified fact, before they have even investigated it, or put it to the test of practical experience and published its failures to the world, as requested by the master.

The following are given in our works on practice and pathology as peculiar, independent, or idiopathic diseases, while to psora, Hahnemann attributes the "only real fundamental cause" of this formidable list: "Nervous debility, hysteria, hypochondriasis, mania, melancholia, imbecility, madness, epilepsy and convulsions of all sorts, rachitis, scoliosis, syphosis, caries, cancer, fungus hematodes, neoplasms, gout, hemorrhoids, jaundice, cyanoses, dropsy, amenorrhœa, hemorrhage from nose, mouth, stomach, bowels, bladder, uterus, lungs, asthma and ulceration of the lungs, impotence and barrenness, megrim, deafness, cataract, amaurosis, renal and urinary calculus, paralysis, defects of all the special senses and pains of thousands of kinds."

So much by way of introduction. Now for the practical application of this invaluable polychrest.

A good working pathogenesis may be found in the Guiding Symptoms, Hering's Condensed and Clark's Dictionary of Materia Medica, from which I have taken the indications given in my key notes and to which I have added my verifications and clinical confirmations. I have been using the remedy cautiously since 1876 and consider it the most valuable anti-psoric in our armamentarium, and wish to give my colleagues who have not tested it some leaves from a chapter of

my bedside experience. If you have never used it, if you know nothing of its wonderful curative powers there is a revelation awaiting you if you will apply it as you do arsenic or sulphur on the totality of symptoms, and do not repeat it too often. I began its use on the advise of the late Dr. H. N. Guernsey, of whom I obtained my first potency, and to whom I have always been grateful for the suggestion. The following indications I have found guiding:

In chronic diseases *when well selected remedies fail to relieve or permanently improve* (in acute diseases sulphur has the same indication); when sulphur seems indicated but fails to act.

In pneumonia, pleurisy or typhoid the selected remedy fails to produce a reaction, because there is a deeper dyscrasia or constitutional miasm underneath; arnica, bryonia or even sulphur may require the constitutional aid of psorinum to rouse the vital reaction.

Lack of reaction after typhoid or other severe acute diseases. Appetite will not return.

The tongue is clean, pulse and temperature normal, but the patient is weak, listless, almost lifeless and every attempt to introduce nourishment is followed by fever or intestinal disturbance. The so-called tonics are generally stimulants and as a rule make matters worse instead of better. These cases, if feeding be forced, frequently relapse, and the relapse is often fatal. The constitutional dyscrasia, the cause of the sudden explosion in the form of some acute disease, has not been reached and requires a deep acting anti-psoric like psorinum.

GREAT WEAKNESS AND DEBILITY: *remaining after acute diseases;* from loss of animal fluids; independent of or without any apparent cause or any organic lesion.

Many cases of this kind are met in practice where cinchona, quinine, phosphorus, kali phosphorica, etc., are given simply for the debility and generally without success, because selected for the disease, the localized expression of the constitutional psoric miasm, and not for the patient.

THE BODY HAS A FILTHY SMELL, even after bathing. All excretions—diarrhœa, leucorrhœa, menstrual flow, prespiration—*have an offensive—even a carrion-like odor.*

This is always a valuable and reliable symptom and has been verified in my practice many, many times. The odor is both objective and subjective and in consequence is very distressing because it affects both patient and attendants. The patient does not object to a bath, as does the sulphur sick, but bathing is useless, it neither cleanses the apparent filthy condition nor abates the abominable odor. A dose of psorinum will improve the condition in forty-eight hours.

GREAT SENSITIVENESS TO COLD AIR, *to change of weather;* wears a fur cap, overcoat or shawl even in hottest summer weather.

We all meet many patients who thus complain and suffer; must be muffled continually, cannot bear the least cold air; cannot sleep without a night-cap or their head covered with woolen at night. This is just the opposite from sulphur, which rarely wants much clothing or covering at night and generally prefers a cool room.



Stormy weather, change of weather they feel acutely; are restless for days before or during a thunder storm; can predict with unerring certainty the approach of a storm, especially an electrical storm.

Phosphorus is sensitive to an electric storm, but it is during rather than before the storm. This entreme sensitiveness to cold and weather changes I have often greatly modified or completely eradicated by the use of various potencies of this remedy.

Anxious, full of fear; full of evil forebodings. Religious melancholia; very depressed; sad, suicidal thoughts; despairs of salvation, of recovery.

Often called for to complete the cure or prevent a relapse after aurum, melilotus and other well selected remedies have relieved the acute stage. Hahnemann claims that insane patients discharged as cured will relapse unless the bodily ailments on which the mental disease depends are eradicated by constitutional remedies. The use of this remedy in our insane asylums would greatly increase percentage of recoveries and lessen the time in the hospitals; and to prevent a relapse should take an occasional dose for weeks or months after the discharge.

Headache: PRECEDED by flickering before eyes; by dimness of vision or blindness; by black spots or rings.

Both kali bich. and lac deflor. have flickering and dim vision or blindness preceding the onset of pain or at beginning of headache; but when the pain becomes severe the dimness clears up. But while these remedies may relieve the severity of attack they rarely make a permanent cure or eradicate the disease.

Headache: *always hungry during;* > *while eating;* from suppressed eruptions or menses; > by nosebleed.

This anomalous condition of hunger during headache with relief while eating belongs also to anacardium and kali phos. and if they are the similimum may cure the case. But this rarely occurs, and if they palliate for a time it will often require psorinum to effect a permanent cure.

QUINSY: tonsils greatly swollen; difficult, painful swallowing; throat burns, feels scalded; cutting, tearing, intense pain, shooting to ears on swallowing; saliva, profuse, ropy, offensive; tough mucus in throat, must hawk continually. The remedy to not only > the acute attack but to eradicate the tendency to suppurative tonsilitis.

Apis, baryta, lachesis, lac caninum, lycopodium or the mercuries may control the acute attack but will rarely eradicate the constitutional diathesis and thus prevent future suffering. When clearly indicated by careful differentiation, we have never found any remedy so promptly curative during the inflammatory stage of quinsy as psorinum.

Diarrhœa: sudden, imperative, gushing (like Aloe, Sulphur); stool, watery, dark brown, *fetid, smells like carrion;* involuntary, < at night from 1 to 4 A. M. (before Sulphur begins); during typhoid or after severe acute diseases; in teething children; when weather changes; when Sulphur > but fails to permanently cure.

Constipation: obstinate with backache (Æsculus and Kali carb.); from inactive or paretic rectum (when Opium, Plumbum, Sulphur fail to relieve or cure).

The obstinate diarrhœa which occurs during marasmus, summer

complaints or typhoid often finds its curative in psorinum when apparently the best selected remedy fails to cure.

Leucorrhœa: large, clotted lumps of an unbearable odor; during climaxis, when Sanguinaria fails; violent pains in sacrum; great debility.

This is one of the few remedies that has a clotted, lumpy leucorrhœa; and no remedy approaches it in offensive odor, the bane of the patient's life.

During pregnancy: morning sickness and the most obstinate vomiting, when Lactic acid and the best selected remedy fails to relieve.

Here psorinum will often relieve this distressing condition of the mother, and what is even of greater benefit correct the psoric diathesis of the unborn child during the plastic period of life. This is probably our greatest remedy, because most frequently indicated, for the pre-natal treatment of the constitutional diathesis, the psoric dyscrasia. Here is a field that especially belongs to the follower of Hahnemann, where his potentized similimum may begin the eradication of constitutional ailments in early life; where the discomforts of the pregnant mother are nature's call for the relief of the unborn child.

Asthma, dyspnœa: < in open air, < sitting up (Laur); > *lying down* and keeping arms stretched far apart (rev. of Arsenic); despondent, thinks he will die.

The position which the patient assumes to obtain relief—lying down—is just the opposite from arsenic, lobelia, ipecac, etc., so that differentiation is not difficult when the mental depression so marked under psorinum is taken into consideration.

HAY FEVER: appearing regularly every year the same day of the month, or in midwinter when exposed to dust, with an asthmatic, eczematous or psoric history. The patient should be treated the previous winter to eradicate the diathesis and prevent the summer paroxysm.

Many a martyr to this distressing affection has been restored to health and enabled to attend to business the year round by the curative virtues of psorinum. But it must be given for the totality of the symptoms of the patient, not for psora or hay fever. The family history of eczema, quinsy, suppressed eruptions, or an uncured typhoid added to the symptoms of asthma or hay fever may clear up the case and make the selection certain. If the patient complains that he or she "has never felt well since an attack of typhoid years ago", it confirms the selection of psorinum and if the remedy be given when called for by a return of the symptoms in various potencies it not only lessens the severity of present attack but paves the way for a complete cure.

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## DISCUSSION.

DR. NASH: *Mr. President*, I did not expect to discuss Dr. Allen's paper, but I want to say that, taking our whole school, there are very few who use, or value, or estimate, as they ought to, the curative properties of the remedy of which he has been talking, psorinum. One reason is because a very great many of our physicians have no faith in potencies above the third or sixth, and psorinum is seldom



used there, but must be used higher, so far as we know. A man does not, very naturally, want to swallow, even for the sake of getting well, a very large dose of itch pustule, but that it is a remedy that is capable of doing a great deal of good, capable of helping the action of other remedies, capable of overcoming the manifestations of the dyscrasia, known as psora, is well known to those who have thoroughly tested it. Now, on this subject, of course, you might talk to a great many physicians from now on and they wouldn't have any faith, or faith enough at least to try it in any potency so high as the 30th, and wouldn't have it in their shop, as I would not when I began practicing medicine with psorinum or any other remedy. Such physicians, of course, cannot come to the truth and understand what there is in such remedies as *Psorinum Lycopodium*, *Sepia*, &c. That remedies do cure in low potencies and as crude drugs, we do not undertake to deny for a moment, but we do undertake to affirm, and that from an experience of forty years, that remedies do cure in the 30th 200 c. m. and d. m. m. So, we say try these things, "prove all things and hold fast to that which is good." If there ever was a man who started off with a prejudice against the use of high potencies, and I say this in regard to the potencies simply because we are using a drug that has only been used in the potencies, and for that reason is not understood by the profession, who are prejudiced against potencies, I started off as prejudiced against what we call potencies as any man ever could be, and had no use in my office for a potency above the sixth, because I didn't want to risk the life of my patients, or do discredit to myself, or to violate what seemed to be common sense. But flat failures with low remedies, and observation of the success of men like Hering and P. P. Wells, Carrol Dunham and such men, induced me to try them, and against my will I was convinced of their efficacy. I only want to say in addition to what Dr. Allen has said of this remedy, that the symptoms upon which Hahnemann places more stress than all other symptoms in the proving of drugs, are the mind symptoms. If Dr. Allen mentioned it I didn't notice it. Psorinum is one of those remedies which like *Aurum Natrum* and Lachesis, depresses the mind horribly. The patient is bound he cannot get well. He is discouraged, and you can't encourage him. He takes the sombre view of life in every direction. His disease makes him so, when he may be naturally a very hopeful patient. Psorinum, especially if that patient has suffered recently from some disease from which he has not fairly and fully recovered, is one of the first remedies to give that kind of a case, and to remove this hallucination that comes over him, that everything is going to the devil, and he, too. I have only a word more to say in regard to this remedy, Mr. Chairman. I fully endorse what Dr. Allen has said about it, and think that of all men in our school of materia medica there is none who understands the properties and use of *Psorinum* better than he. You remember I alluded to some other remedies, and these comparisons are very useful, because we often find a class of remedies covering those hopelessness cases which come to us, resulting from different causes.

If I should have a case of that kind come to me, that came on after a disease not cured, or only partly cured, why, I should say my mind would be immediately led to *Psorinum*. If on the other hand, I found those cases coming from a badly cured syphilis, I would think of *Aurum*, and especially if the patient wanted to commit suicide, although that symptom also comes under *Psorinum*. If we found a man filled up with quinine, chill suppressed after chill, and found him also plunged into this melancholic state, we would immediately think of a remedy that has melancholia as its indication, and *naturum muriaticum* in the 200th or 2000th and cure the patient. Then, if you found a woman at the climacteric, and having the other symptoms—other things being equal—we would not look at either one of these at all, but find our remedy in Lachesis. So that we have to take into account and very carefully guard against one remedy because it covers one particular symptom, and the greatest need along the line of prescribing is in the direction in which Hahnemann said, that the peculiar characteristics of the remedy must apply to those that are peculiar and characteristic in the patient; so that we get a peculiar symptom, and we say that peculiar symptom is in the patient, but we must remember that that peculiar symptom in that patient can be covered by half a dozen remedies, and we must look to the one that covers all the peculiar symptoms. (Applause.)

W. S. MILLS: We would like to hear from Dr. Dewey if he has anything to say on this paper.

W. A. DEWEY: *Mr. Chairman, Ladies and Gentlemen*, I cannot say any more than has already been said. Dr. Allen has given us a brief resumé of Hahnemann's theories, his three dyscrasies, psora, syphilis and sycosis. Modern pathology, it seems to me, has approached Hahnemann somewhat in what we now denominate as tuberculosis or scrofula. It is all the same thing, and nothing but a re-statement of Hahnemann's psoric idea; and as mercury is considered the great anti-syphilitic, and thuja, the great anti-sycotic, so psorinum may be considered the great anti-psoric, or tuberculic, or anti-scrofulic remedy, if you are so pleased to call it. Not that these diseases may not be met by other remedies, but these are the chief remedies for those dyscrasias. Now, the action of psorinum in cases where well selected remedies fail to act, is sometimes marvelous. I can recall some cases of eczema capitis on which I worked in a dispensary clinic for six months trying to cure them, a good many years ago. I think I can prescribe a little better now than I could then—perhaps not much—but I certainly worked four or five months trying to cure a couple of cases of eczema capitis. Every time they came back with the same cry, "No better, sir," "no better, sir." They had more patience than I would have had with a doctor treating me, but they still came; and finally I hit upon psorinum, and the very next time they came back they said they were better, and the cure went on speedily from that time. It was simply a case where I failed to appreciate the reasons for prescribing psorinum for several months. Among the symptoms present in those cases was one that was given by Dr. Allen, and that is, that the bad odor of



the head, and not only of the head but of the body, seemed to persist, and no amount of washing would do away with that odor. I have learned to highly respect psorinum. I do not use all of the nosodes. I do not know enough about them to use them, but certainly those that I do use—and psorinum is one, and tuberculin is another—I have learned to respect very highly, and none more so than psorinum.

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## WHAT WE NEED IN MATERIA MEDICA TO-DAY.

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It is pretty clearly demonstrated that neither this generation nor the next will reap much benefit from the reproving of drugs.

At the present time we are caught on the flood tide of surgery and hygiene, and are swept along by a resistless current. After a time the tide will reach its highest point, and after the ebb, a new tide will follow, the tide of drug therapeutics.

What shall we do meantime to make such progress as we may?

There seems to me but one course for us to follow: the course of *symptom confirmation*. The basis of the drug cure of the future is just as sure the conclusion to be deduced from the physiological action of the drug compared with its curative action, as is sure the rising of the sun to-morrow.

The results of this comparison have been foreshadowed long. They lie just beneath the surface of every reliable book on drug therapeutics. Drugs will cure, and always do cure when administered in small dose, by the rule or law of similars. The fact is too patent to need argument, and the demonstration is found in every reliable medical therapeutics.

This phase needs reiteration for the sake of the ignorant and the prejudiced, but it is as fixed as the central position of the sun in the solar system, or the influence of the moon on oceanic tides.

What is needed is not renewed demonstration of the physiological action, but a sifting of alleged physiological action by the bedside.

Materia medica is large enough already, too large. No man can use well and accurately one-third of the drugs already fairly well known. In our present materia medica is a gold mine. But like the terrestial aurific deposits, all lodes do not produce equal grades of paying dirt. Some are rich as one could wish; others have scant value.

Where is the best paying lode and how shall the deposits be worked to the best advantage? This is the question of questions in drug therapeutics.

There is but one test, that is the one already mentioned, the clinical test, the empirical proof.

Grains of gold are being sifted out by thousands upon thousands of workers every day. We all own gold fields equal in extent. But we do not all know how to work them equally well.

We can learn by the experience of others where to look for a sure nugget, and how to distinguish the true metal from fools' gold. It is this experience, that is so valuable to every worker, of which we are so reckless and so prodigal. To gather all these reliable experiences into one safe book—storehouse—is the real business of present-day drug-therapeutics. Let me illustrate by one or two small grains.

Did you know that the unmarked little line in Hering's Guiding Symptoms, in the pathogenesis of Actea Racemosa, or Cimicifuga, as it is also called,

"Dry spot in the throat causes cough"

is pure gold? That taken with the next line which is double leaded

"Night cough, dry, constant, short,"

and the next line which is single leaded,

"Cough at every attempt to speak",

is as reliable as the sun in heaven? Well, take it home with you, and when you meet that condition in your patient give the 3x, and go away conscience free.

Do you know the value of that short line under "13 Throat" in Gelsemium, single headed in the text,

"Swallowing causes shooting in the ear",

and its iteration near the bottom of the page,

"Shooting pain in the ear when swallowing"?

It is again reiterated on the top of the next page.

"Inflammation of upper part of throat, and shooting pain into ear when swallowing; hardness of hearing."

If you have a patient with "pains all over", especially in the back and limbs, some frontal headache, great prostration, inflamed throat with agonizing, shooting pains from tonsils into the ear when swallowing, in short if you have a case of incipient suppurative tonsillitis, from cold, from infection, from malaria, from anything bacteriological, infectious, or central nervous, give Gelsemium tincture in two or three drop doses, ten minutes to half an hour, until the head swims, and you will rout the enemies' hosts foot and horse. Never mind how or why, whether the "nidus is destroyed", the "culture media changed", or the "bug" paralyzed; all the same if you get after him or his hosts early enough he will take French leave, and you will wonder how he could have folded his tent so quickly and stolen away so silently.

Have you a case of earache in a child; turn under this same drug, Gelsemium to "6 Hearing and Ears." Read a more prolix statement.

"Earache from cold,"

single headed, and following immediately,

"Catarrhal inflammation, *at the beginning;* cold in head and closure of eustachian tube; tense, dull, bound, giddy sensation in head, with chilliness; stupor, drowsiness."



This is the ear side of the same picture whose throat expressions we were so closely watching just before.

Do you know where the biggest nugget lives in this prolix recital? It is just two words: "*at beginning*". These are worth more to the aural therapeutist than all the knives and nostrums ever invented, if he gets his case "*at beginning*".

Give your little patient the 1x or the 2x, in one, two, or three drop doses in water every ten minutes to half hour. Go home, go to bed; you won't be called up in the night, and you won't have suppuration of the middle ear. Neither will you have deafness following an attack of catarrhal inflammation of the middle ear.

Now my medical brother, there may be grains of gold that you have found for yourself. They have long lain in the mines of every homœopathic practitioner in the land. Of course, many have found them, but, also, many have not. You have found many more grains, in many other mines of yours, than I have yet found. Suppose we establish a medical exchange, and you bring your wares and I bring mine. I don't want any of your "fool wares." I can generalize the materia medica for my own purposes just as well as you can. I don't want any lectures on the "genius of the drug", that is too cloudy. What I want, and what you want, is a definite symptom laid down in the books, or that you can lay down if it is not in the books, upon which you and I can rely when it is clearly understood. This will, in the aggregate, constitute the materia medica of the future.

It is not etiology, it is not pathology, it is not bacteriology, that is going to cure the patient. In preventive medicine these are useful, they are more, they are indispensible. But in the actual sick room they are often negative quantities; in treatment they are generally useless. Prognosis is useful in a way, but prognosis is often at fault. He who can upset unfavorable prognosis, with his sling of experience, and his smooth, round stone of the right remedy, will win in many a seemingly hopeless contest.

Finally, how shall we gather in the scattered grains of gold and make them useful to every one?

# REPORT

OF THE

# BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.



## THE PRACTICE OF MEDICINE AS A SCIENTIFIC PURSUIT.

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I trust, Mr. Chairman and Gentlemen, in listening to this paper you may consider rather carefully the exact statements which I have made, because in the reading of a paper it frequently is a matter of very great ease to gather an idea which the paper itself neither conveys nor is intended to convey, and I have, therefore, written it with considerable care, and I trust that in the discussion that follows the criticisms that may be made may be on what I say rather than on what those of you who hear it think I have said. (Applause.)

When we think of the various sciences and their progress during the world's development, we realize that the one fixed fact in the sphere of knowledge is that there is a possible beyond to everything, that nothing is so sure within our grasp but that to-morrow may change its whole aspect to us. What we regard as a fixed scientific fact to-day may come back to us from another's hands with such additions or subtractions as to give it a wholly new meaning.

The "facts" of science have been thus progressive and we conclude, therefore, that it is not so much the collection of facts in any branch of knowledge, as the attitude of mind toward these facts that gives it, and the men who concern themselves with it, the right to be called "scientific".



I mean to say that any subject may be so engaged in as to become either an art or a science, while an art or a science may be pursued in such a manner as to render it neither artistic nor scientific. A man may call himself a scientist, may even get himself called so by a considerable portion of the world's students, and yet be unscientific both in mind and method. The primary characteristics of a truly scientific mind are openness, fairness, freedom from prejudice; without these how may any man find truth? The scientific method is also characterized by the clearing away of the personal equation, and not all who would be called scientists are great enough to pursue an end by this means. Yet the tendency in all modern thought is toward this direct, open, impersonal, systematic, but mobile, in other words, scientific attitude. We find it influencing not only intellectual but material progress. Not only has the higher criticism modified the belief of the christian world in regard to religious questions, not only has the reluctant acceptance by our fathers of the Darwinian theory given an entirely new outlook to the youth of the present generation, but the politics of to-day tend toward a foundation of economics, and economics is less theoretical, and more dependent upon social studies of the most exact and careful nature. Business also is employing scientific measures, and the success of the great industries that are the marvel of the century is largely due to this fact.

America is rapidly taking the lead in the great enterprises of the world, gaining control of its markets, influencing the policies of nations, becoming not merely a power but a dominant power, because she is applying practical scientific methods in every field where energy is to be spent, and because she is quick to feel every change of pulse and to meet varying conditions as they come.

Times change and men change with them. Methods and policies that were sufficient a few years ago, if still persisted in, are seen to be pathetically inadequate to-day. We could not, if we would, change these things. It makes, practically, little difference what we do individually. We modify, but we cannot prevent the world's advance. We cannot push back the coming tide, but we may take things out of the way that might be caught by the inwash of the waves.

The history of medicine has been a mirror of the thought of the age. As there was a time when a "Congress of Religions" would have been impossible, when a congregation of Baptists holding church services in a Jewish synagogue was unthinkable, so there was a time when the idea of medical unity was a chimera, beautiful in theory but out of the question as a possible reality.

The waves of progress that have rolled steadily on, have, at each successive ebb-tide, carried some remnants of tradition, of prejudice, of personal feeling. The medical profession of to-day is imbued with a spirit that half a century ago could not have been dreamed of. Difficulties that seemed insurmountable have been overcome, not merely in the way of technical achievement, but in the many fields where exact investigation and infinite pains have been rewarded by discoveries of constant benefit to the suffering. But almost better than these, because it has made such achievements possible,

is the habit of thought which has been attained; the open, fair, unprejudiced, impersonal, exact, in other words, scientific, attitude of mind which has become characteristic of the medical profession, as it has of the leaders in every branch of the world's progress.

Again, the spirit of the age is co-operative. It recognizes the fact that twenty men working together have more than twenty times the strength of one man. Where a business firm once employed ten men and had two partners it would now have twenty partners and employ a thousand men.

In organization and co-operation is strength. This is a modern watchword. One may or may not believe in the amalgamation of great interests, but it is going to be tried. We might put out a hand to prevent it, with the result that we would doubtless lose the hand and nobody be any better off in consequence. The benefits of organization and of co-operation are unquestionably many, and they are going to be tested as they have never been tested before, for the tide in that direction has just set in. It has long been apparent that medical co-operation was sure to come in the near future. The mental attitude of the profession made this certain. The whole question of school will ultimately be done away with, because it is unscientific. A method of medical practice is capable of demonstration or of disproof, and for a whole profession to be divided on such a point is too absurd to much longer be permitted.

But demonstration or disproof are not the work of an hour, and for many years to come the members of the profession may hold different views and use various methods in their work. There is no reason, however, why the men in the profession should not meet the spirit of the times in this, as it has in other ways, and co-operate heartily in the advancement of their common interests and the solution of their common problems. It would give a strength and a dignity to the profession to be thus united that is impossible to any branch of it in a dismembered condition. A division of strength is an obstacle to the greatest achievement, and is seen to be in every branch of the world's work. The time has come now when the far-seeing in the medical profession perceive this, and know it to be true. They know also that because men differ in some of the essential details of their work, is no reason why they should fail to take advantage of the great union, which does not consider what this man or that believes, but only "has he a proper medical training and the character of a gentleman?"

Beyond that no man dictates to another how, or upon what principles he shall do his work, because medicine has not become an exact science, and will hardly become so while no two human machines are built alike, or require precisely the same handling.

If all qualified medical men were to unite in one great association, it would not only add to their own individual strength and to the working power of the whole, but it would be the step into rank that would put the whole profession into the line of progress. This is not only true, but it is going to be done. If not now, then after the waves have done their work. That which stands in the way is not difference of opinion or of practice. It is tradition, it is prejudice, it is personality, it is desire for victory. Many can see far enough into the future to realize a little of what the result will be when these are swept away. Some few will help, and all the years to come will be their debtors. Because, until this union is accomplished, individual men may work on scientific lines, the majority even may be true scientists, but the profession, as a whole, cannot be looked upon as a scientific body while it is divided by a question of belief.



The demonstration of the universality of the dual action of drugs, has not yet been made to the satisfaction of the entire profession. But it is difficult for a man or a body of men to demonstrate anything to other men whom they rarely if ever meet.

If a theory is demonstrable and its acceptance a thing to be desired, the way is surely not to build, or to perpetuate, barriers between those who hold this belief and the rest of the world. If those whom the bigotry of a past age excluded from comradeship with their fellows, did not build the barriers, those who have succeeded them do to-day perpetuate these barirers if they are not willing to have them abolished. The breaking down of the barriers which have existed between the different branches of the medical profession does not mean that all its members shall be called upon to think alike or to adopt any uniform method of work, or in any way to change their beliefs or their individuality or even their associations. That they should not be called upon to do this, is indicative of the broad spirit of the times and marks the passing of intolerance, the coming to the fore of the truly scientific spirit.

If the time has come when it is possible for all properly equipped gentlemen to join in one organization, the failure to do this throws the burden of explanation upon those declining. It has been said during the past few years by many physicians that they could not join a general medical organization, because it would not grant them "freedom of thought and practice". If the level has been raised so high that there is no longer any question of "what do you think"? but only "what do you know and what can you do"? this one insuperable obstacle to a united profession is taken away.

This is a very high stand to take, and to many it will seem an altruistic one. But it is the only truly scientific position.

A belief is not a voluntary thing. One may remain in ignorance because of unwillingness to put oneself in a position to gain facts. But the possessions of the same facts will not always lead two men to the same conclusions.

Is it not Heine, who says, "we do not possess our beliefs, our beliefs possess us"? Having certain data it is not within our power to say that we will or will not believe the conclusions to which these data have led others. Therefore, neither the acceptance or denial of a belief, can be the basis upon which a scientific society admits, or denies admission to a scientific man. At the same time it will be remembered that the practice of medicine has so broadened and enlarged during the lifetime of most of us, that the giving of drugs, important as this is, has come to be a very small part of the measures used by physicians in the treatment of disease. We have come to

realize that the normal condition of the human economy tends to maintain a harmonious adjustment of all of its functions. When these functions have been disturbed, the first effort of the modern physician is to find where a disturbing element has entered.

Has the physiological chemistry been so imperfectly performed as to produce a toxine? Is faulty metabolism due to dietetic errors? Has the vulnerability of the system been so great as to make germ infection possible? Have the psychological conditions disturbed functional activities, or has the nervous tone been reduced by some unsuspected reflex? Into all these fields of investigation the physician must go, correcting conditions which may have given rise to disease, and all these precede and sometimes render unnecessary, any drug giving.

The first question that the careful physician of to-day asks himself is not "what shall I do to make this man well", but "what has he done to make himself sick?" Very few, therefore, of the men who differ from their fellow practitioners in the matter of therapeutics only, are willing to be called or to call themselves sectarian; they do not feel themselves to be so.

Differences of belief have been emphasized long enough, it is now time to emphasize that which we hold in common.

But upon those of us to whom a therapeutic law, immutable and invariable, is not a belief, but a conviction, rests the duty and responsibility of so formulating it that its demonstration must of necessity be accepted by the scientific world.

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## DISCUSSION.

G. E. GORHAM: *Mr. President and Fellow Members:* In listening to Dr. Lewis's paper I am reminded of the speaker who said in his introductory remarks: "Gentlemen, what I am about to say I shall probably allude to." Dr. Lewis has alluded to the onward march of science. He has called our attention to the trend of modern thought. He has prophesied, painted and held up to our view the beautiful picture of the medical millennium, when the medical profession shall be a united body. United in the bonds of matrimony to dwell in peace and harmony forever. It is customary when a wedding is to take place for the bride to make some preparation. She must be properly clothed. She must hold intelligent and proper ideas of her relations and duties to her husband, if she expects a happy and useful life. The bridegroom, too, must make some preparation. He must have a place to put the wife and be ready to accept her with any and all of her mental and physical equipment. Now it seems to me that similar preparations must be made by the two schools of medicine before we can be united as a body. As inidviduals we are fast uniting, and God speed the work. It seems to me that if we are to accept the proposal to unite with the old school, that we should be properly clothed and in our right mind. If we enter the family



holding to, and trying to defend the proposition that pathology is of little account and that the *sine qua non* is a thorough knowledge of the homœopathic materia medica; if we are to spend our energy in trying to convince our medical brothers that the 30th dilution of calcarea carb., when indicated by the symptoms, is the best remedy to adminster to allay the pain caused by the passage of a renal calculus; if we are to teach that the symptom virtigo from scratching behind the ear is of more importance in deciding a line of treatment than a knowledge of functional derangement or pathologic changes which may be taking place, I fear the union will be neither pleasant nor profitable, if possible. And again, if we are to enter that would-be happy state and hold to that old feeling of enmity and hatred toward the other school which some of us do hold, and consider it only loyalty to our cause, and call an honest, educated physician, an old allopathic, and sneer at him because he cannot accept the Hahnemannian theory, I fear there needs to be some change of heart before union in anything except name can be brought about. If we are to offer for membership recent graduates who say that the proper dose of F. E. of Dig. is a teaspoonful and that of sulph. strych. 3 grains, I fear we will be charged with not having had proper medical training. If we are to enter the ranks of the so-called regular school, and advocate the treatment of diphtheria with the indicated homœopathic remedy, and decry the use of diph. antitoxine, we shall again tax the patience and good nature of honest men. A few years ago there was much talk and some intelligent effort made trying to bring about an alliance between England and the United States. Insurmountable obstacles soon presented themselves. When war with Spain was declared and some of the European powers began to prepare to join with Spain against us, England extended her hand and formed an alliance more firm and true than could have been formed by any treaty. Let us form an alliance in spirit with all honest medical men. Let us not hate and call names. but let us love and admire. Is not the discovery of the method of contracting yellow fever of more importance in staying the ravages of that awful scourge than any system of administering drugs? Is not the discovery of the marvelous therapeutic value of the X-Ray of value greater than any homœopathic remedy known. Is not the use of urotropin in an infected bladder a more efficient remedy than can be found in the homœopathic materia medica? To whom is the medical profession indebted for these discoveries, these blessings to humanity? This is an age of scientific investigation and research. Let us unite in a spirit of fairness and honesty and seek truth and be glad to drop error even if it takes from us the teachings of our ancestors and compels us to admit we were wrong in some things. (Applause.)

E. B. NASH: I have been very much interested in this paper, Mr. Chairman, because there seems to be in it a spirit of fairness and of a desire to be scientific. My attention was called a few days ago to the fact that this question would come up, of the advisability—perhaps I use different words—of entering into a coalition, or form-

ing an amalgamation, with scientific medicine, no matter by what name it was called, or with any school or set of schools who termed themselves scientific and expressed their desire above all things to seek and do that which was right. But we must remember that while consolidation may increase power, amalgamation of truth and error always weakens. Not only that, but that liberty of medical opinion, while it is a good thing, carried too far, becomes license to think wrong and do wrong; and there is a difference between license and liberty. I remember the story of a man who became converted, and who expressed himself about in this way: "Brethren, when I used to be a sinner I loved the devil and hated God, but this religion of Jesus Christ is a religion of love, and since I have become converted I have learned to love God and the devil both." (Laughter.) Now; we do not want to be too free to accept everything in a spirit of love even; and thinking along this line I just wrote down a few words that I want to read. It expresses my opinion, and I want to put it in this way, because I can read it, having carefully thought of it, better than I could speak it extemporaneously.

We want to be very careful how we take steps in the direction of the amalgamation of truth and error. We have stood for a hundred years against the most unreasonable persecutions, and fought for principles that we knew to be true, until we are the peers of all other schools, in the eye of the law and the confidence of the public. The law of cure promulgated by Hahnemann has stood the test, and we are not driven, every decade, to resort to some system of microbe killing or sero-pathy. The only law of cure ever discovered that stands to-day as it did a hundred years ago is that represented in the formula, similia, sim. cur. We are its sole custodians; not that every one has not a legal right to avail himself or herself of its beneficent possibilities, but that no one has a moral right to do so without open acknowledgment of its truth. We follow in the steps of Hahnemann, our Herings, Raue's and Lippe's, our Joslyns, Dunhams, Bayards and Wells, gone to their rewards. Our Helmuths, Allens and Descheres of later times, who have placed our school in a position where it has, does, must and will command the respect and recognition of the people in spite of all possible opposition. Now, if the old school, or as they delight to style themselves (as a reflection upon us), the regular school, have come so far as to invite us to their society meetings, allowing (mark the word) us to retain our name, etc., we ought to hail it as a forward movement on their part, and accept the invitation. Yes, and return the compliment. But it is due to ourselves, the government that recognizes us and the public that appreciates and patronizes us, to abate not the tithe of a hair from a full claim to recognition of the truth of the principles that have made us distinctive as a school. Homœopathy is a success. No sane man can deny it and it has come to stay. There is no good reason why this amenity should not have been extended to us before. There is nothing but an unwarranted prejudice that has ever stood in the way of a recognition of Hahnemann's teaching, potency and all. In the name of general medicine we have ever admired, accepted and



studied the anatomies, physiologies and chemistries and operative surgeries of those who are recognized lights in all so-called schools of medicine. There ought to be no such thing as different schools of medicine, and when the dominant school shall honestly investigate the claims of homœopathy, and as scientifically apply it to the cure of the sick as they, divested of prejudice, are capable of doing, the time is not far distant when there will be but one school and that will be homœopathic. When the time shall come that a man may display the works of Hahnemann, Hering, Raue, Guernsey, or any or all of the now large and able works on the homœopathic treatment of disease, on the shelves of his library, or deal out the sugar globule, disk, or tablet according to his judgment of the needs of his patient, without being "called down" by his county, state or United States society for irregularity, then will there be some reason for us to accept in good faith, courtesies extended to us, and less reason for our continued existence as a separate school. Until then we must stand on our dignity, assured as we ever have been, that "Truth crushed to earth shall rise again and just as surely that error wounded shall writhe in pain and die amid her worshippers." (Applause.)

G. T. MOSELEY: *Mr. Chairman*, I believe there is no question but that every person in this room believes in the law of *similia*. If we did not we should not be here. We heard last night from the lips of our venerable friend, Dr. Biggar, the suggestion that we should do a little evangelistic work. We have heard just now that the old school should accept our belief. Now, in fairness, gentlemen, I ask you, how shall we expect a body of scientific men to accept a belief of which they know practically nothing? and how shall we expect them to know anything of our belief unless we carry the war into Africa and teach them something of what we believe. If we maintain our position on the one side, and decline to meet the gentlemen of the medical profession half way, we are doing two things. In the first place, we are depriving ourselves of the benefits which may result by the contact of scientific minds working along similar lines, if not identical lines. We are depriving ourselves of the benefit of their investigations, which we all use, mind you, perhaps six months, or a year, or two years, late, because we get the information second-hand from books and from journals, rather than by word of mouth from these men whom we decline to meet; and, second, but not less important, we are depriving these men of the benefit of our observation and experience with the law of therapeutics which we believe to be the truth. Gentlemen, if our law of therapeutics is true we can afford to place it by the side of any other system of therapeutics in the world. If it is true, it stands. What is of no use in our system might better be culled out by the winnowing through which it will pass under the close scrutiny of our friends of the opposite school. Now, gentlemen, I beg of this society, that above all else, we be honest with ourselves. We should be honest with the other school. We accept their methods, we practice their methods. I believe there is not a man of us to-day who is not constantly using in his daily work—it may not be in the prescribing of drugs, but in the treat-

ment of his case—the methods and the discoveries that have been made, not by our own men, but by our friends on the other side of the fence, and it is due to them to give them the credit which we ask for ourselves when they use our methods. For years we have claimed that the old school were stealing our methods, they were using our drugs, according to our indications, without giving us the proper credit. Are we not doing the same thing? Are we not using old school methods constantly in our work, and giving no credit? Let us be honest with our friends, the enemy, and at the same time let us be honest with ourselves. Let us not get up in our societies and talk homœopathy, and a single remedy, and the higher potencies, and go out in our daily work and prescribe compound tablets and a variety of old-school treatment and give no credit to anybody. When we come to the point where we preach what we practice, and practice what we preach, then we can hold up the banner of *Similia Similibus Curantur* and stick to our creed, and flock by ourselves and refuse to meet the gentlemen of the other school when they make overtures to us. We are losing nothing by meeting our friends of the other school half way. We may gain a great deal. Let us maintain our own views, let us maintain our own societies, our own institutions, but, gentlemen, let us proclaim the truth, and let us place our societies side by side with theirs. If it is true, it stands. What is false, let us drop, and let us drop it right away.

L. A. MARTIN: *Mr. President*, I think if there is any chaff to be winnowed out of the homœopathic wheat, it had much better to be winnowed by ourselves before presenting it to the old-school. Let us present homœopathy to them in all its purity, and let us get the credit of having something that not only is of value to ourselves but of value to them. (Applause.)

DR. AUSTIN: *Mr. Chairman*, it always takes two to make a fight, and it would seem from what has been said that we have been doing all the fighting and giving in at no time. I have seen something of the old school. I spent three years there. I know most all the old-school men. I come in touch with a great many old-school men. I say to you, they are no friends of ours. Let a student spend three years in the best new-school college in the country—as they call us—and then go over to the College of Physicians and Surgeons and say, "I would like to know something about your materia medica. May I come in here, spend a year and finish?" They will laugh you to scorn. But let a man spend three years in Harvard Medical College of Physicians, or any good old-school, and come to the new, and they will take him in and show him all there is to know about homœopathy; and, as to-day I stand on this floor loving homœopathy and the men that have raised its beautiful banner—they have been trying to change—Osler himself asserts that in twenty years he has changed his ideas four times, and he says, "What shall I teach the student?"—and after they have been drifting around and grasping at the last straw, and they have become interested in our lines, they are now making us think that they are loving us—and I have heard



old men say in the Academy of Medicine that the only way to treat an enemy was to love him to death (laughter and applause)—I tell you, look out for them. I went to a surgeon in the United States Navy just two weeks ago, and we were talking on these lines, talking about antitoxin, and I said to him, "It seems so strange to me that you are so awfully careful on your vessels that everything shall be surgically clean, and yet you take that rotten pus and put it into a man's arm,"—because I was at the College of Physicians and Surgeons when they inoculated those horses, and many of them were not the best—sick horses at that. I said, "How can you make that right? How can you approve that in your mind logically? Can you explain that in your own mind?" He says, "No, I can't, doctor, but what is a fellow to do when the government tells him he must?" He says, "When I was in Bermuda, small-pox broke out and I was obliged to vaccinate the men. If I didn't vaccinate them I would have to leave." There is a man who has not strength of character enough to leave the United States service. (Applause.)

W. B. GIFFORD: It seems to me, Mr. Chairman, we have heard both sides of this question from Dr. Lewis and Dr. Gorham, but I believe there is a practical side. I was fortunate, or unfortunate, enough to have been educated in the old school, became a homœopathist twenty years ago, and it is not necessary for me to say what I have gone through with the old school, the fights I have had with them, ostracized in every way. I cannot believe the old school is honest in this matter. This whole thing started, it seems to me, in Western New York. It has not pervaded the country very much. I learned last night that a pathologist had been appointed from the old school to the Homœopathic College in New York, a position which he had accepted, and has been invited to withdraw from some of his societies in New York for having associated himself with our college. This does not look to me like medical unity. In an article in the *Buffalo Medical Journal* a short time ago by one of the leading allopathic physicians, he said that we were not homœopaths in principle; it was an academic question, we were brought up under homœopathy. He stated that the homœopathic physician had not become imbued with the ideas he held because he believed them, but because it was a matter of education, and as soon as his mind became broadened he saw the fallacy of homœopathy. I believe in medical unity, and I believe a great deal in what Dr. Lewis and Dr. Moseley say, but it seems to me that the suggestion is ideal and not practical, and that if we take this important step now, our organizations will soon be broken up. I believe it is the same old fight under a new cloak on the part of the old school. (Applause.)

J. W. SHELDON: *Mr. Chairman*, I cannot let this discussion go by without saying a word, and I wish to, as one of the older members of this Society, for as I am termed one of the old practitioners, I rise to admonish the younger practitioners of our school to go slow and be easy in these matters. I realize that years ago the old-school did not tolerate our system, or our views. When I commenced practicing medicine there was not an allopathic physician in the country

that would not shoot a homœopathic dog that came into his yard. Now, gentlemen, they not only tolerate the dog, but they even tolerate his owner; they even invite us to join their societies. I believe in harmony and in practical common sense in all things, but I do believe there is something in homœopathy, or homœopathy would not exist to-day. I believe, too, that it is possible for a man to practice homœopathy absolutely without the use of many means and methods which have been developed and presented to the public and to the profession by the old-school physicians. I believe homœopathists adopt many of their methods, many of their adjuvants as auxiliaries in their practice, and it is true at the same time, that their practice has been modified and they are using more of homœopathy to-day than they were thirty or forty years ago. When I commenced practicing medicine in Syracuse thirty-seven years ago, it was an unknown thing almost for an allopathic physician to consult with a homœopathist; yet within the last three months I was in consultation with the president of the Allopathic Society of the State of New York. You see, gentlemen, what changes have taken place in less than half a century. You can realize in looking over the history of the practice of medicine, what great advancement has been made in our school in one hundred years. Now, I say, gentlemen, if the old school, as they call it, or regular school, have seen those things in our school which have commanded their respect, which have led them to view us as a respectable, honest and educated class of men, and have gradually become willing to approach us, to extend the hand of fellowship—as they call it—it shows positively that there is something in our practice, in our school that commands their attention, that they know will not die, and that they cannot kill, so they are satisfied to take us into their fold. Now, my advice is this: for us to go slow. I have found that in trading horses when a man makes an offer and it is not accepted, he will very soon make another offer. You can very soon have the thing your own way if he is anxious to trade. Now, if the old school is anxious for this union, anxious to incorporate our body of professional men, the day is not far distant when they will make greater overtures, and we shall be able to make our own terms. (Applause.)

H. C. ALLEN: I want to take exception to the remark of Dr. Sheldon, in which he says, "We" use their adjuvants and palliatives in our practice. I do not want to be included in the word "we". I have no use for their palliative or adjunctive treatment whatever. Homœopathy is good enough for me, it is good enough for my patients. I get along with all the cases without morphine or any of their crude drugging whatever. I do not use the hypodermic syringe. We can get along in homœopathy without any of their traditional palliatives. I would like to go a little further and make a suggestion, because I want to congratulate Dr. Lewis upon that paper this morning. It is an admirably written document. It was in fact very persuasive. It was so soft, so gentle, so mild and so molasses-like, I almost imagined that we were going to have a lot of the allopathic physicians in here to discuss this question. Suppose we try, now, as



homœopaths, educated in the best homœopathic colleges we have, and make application for admission into the army or navy of the United States. Do we get in? Do we get in as homœopaths? Are we allowed to be examined as homœopaths? If we succeed in the examinations can we practice homœopathy in the army? If we pass the highest examination they are capable of putting up and come out 100 per cent. in everything, will we get the appointment, if there is another man ten, or fifteen, or twenty per cent. below us? Not much. Just as it occurred here in the city of Utica a short time ago—one of our homœopathic practitioners passed an examination for a position in this city. He stood higher than any other, and it went before the board. Did he get the position? No. Our English brethren have been trying, for many years, to advance homœopathy by converting allopaths. They have given it up in despair and may now use some other methods. Now, some of our allopathic societies are opening up their doors and inviting the homœopaths in. Suppose we try it. Invite some allopathic physicians to attend our society, and see how many will come. Put the boot on the other foot, and see how it fits. Oh, no. I have been with Dr. Sheldon forty years; I have stood their buffs and rebuffs and all the vile names they could heap upon a professional man, simply because he exercised the right of a physician, of practicing what he believes to be right. Did they consult with me when I first began to practice? No. Will they do it now? Yes. Why? Because they dare not refuse. Let them come over and make some of the advances. It was the allopaths of Germany who ostracized Hahnemann. Let them take back part of the abuse they showered upon his honored head, and then we may talk to them. (Applause.)

J. W. SHELDON: In answer to Dr. Allen, may I say that perhaps my use of the word "we" was a little too sweeping. I might say "the majority of homœopathic physicians."

J. W. CANDEE: *Mr. Chairman and Gentlemen*, This discussion is intensely interesting. We all recognize the importance of the subject. There is little left for me to say, yet I do want to add a word or two. The homœopathic school of medicine reminds me of the Episcopal church. In that denomination are widely varying grades of belief, from that of the low churchman whose form of worship is very simple to the elaborate ritual of the extreme high churchman, the difference being so great as to almost defy recognition that all belong to the same sect. Yet they are under one bishop—all Episcopalians. This is, I think, quite analagous to our low potency and high potency differences and may include the question of use of palliatives, etc. Our variances in belief and practice are honestly entertained, and we are homœopathists. In a line-up for a fight I fancy all would be found on the right side of the fence. This lovely, scientific, truly artistic picture that Dr. Lewis has held before us is most admirable. It ought to be carefully considered. The doctor and others have presented an ideal of unity, progress and brotherly love which is delightful. Yet, as Dr. Gifford has wisely suggested, there is a practical side to be considered. We can hardly do busi-

ness on the lines indicated by Dr. Lewis and Dr. Moseley. Ideals are good, but can we use them every day of the week?

We, of Syracuse, have been invited to participate in this movement. It is in many respects an acceptable proposition; rather flattering in view of all that has past. But, gentlemen, we must be convinced of the fairness, of the good will and appreciation of our merit on the part of the old school, which this plan purports to carry. I wish that we might feel assured of ingenuousness in this proffer. We cannot forget ancient history as read in Virgil, so we, too, must say "*Timeo Danaos*". (Applause.)

E. A. SIMONDS: *Mr. Chairman*, I can well understand the feeling that is in the minds and hearts of these pioneers of homœopathy, but I must say that from personal observation as one of the younger members of the profession, I have never had anything but the most courteous and most kindly treatment from the members of the old school. I have never found them to be such wolves as some of you have been unfortunate enough to find them. The day when witches and Baptists were burned and hanged has long passed. The day of the Inquisition has passed. The spirit of the times has changed. I believe we are fast drifting toward the time, if it has not already arrived, when these line fences may be cleared away, when we can become one band of scientific men and treat one another as friends and brothers.

DEWITT G. WILCOX: *Mr. Chairman*, when the spider invited the fly into his parlor it would have been a very foolish thing for the fly to have entered in entire ignorance of the spider's strength, his tactics and the furnishings of the parlor. But if the fly had spent a hundred years in developing its own strength, in learning the weak points of the spider and knew all about the furnishings of the parlor, the situation would have been changed vastly. Now, gentlemen, this amalgamation is bound to come sooner or later, and we cannot stop it. The thing we must consider is how best to meet it. I do not like to hear the question put as an amalgamation of truth and error. When we attend their post-graduate schools, buy their text-books and learn all that they have discovered in the way of pathology and preventive medicine, and adopt it every day and use it in our practice, we cannot speak of that school as being in error. They may differ from us, and they may be in error in regard to the exact administration of remedies, which, as we all know, is simply one branch of the practice of medicine to-day—and ours, we believe, is right. I cannot believe that if this whole State Society, with its intelligence and its independence, were injected into the Old School Society, we would be absorbed. Our belief in homœopathy is too strong ever to let that take place, and I believe, on the contrary, that homœopathy would be stronger, that it would be practiced more generally and that we would be recognized more fully because of such amalgamation. Now, I do not know how this is going to come about. It seems to me to be a great deal like the period of reconstruction after the war; and there are going to be a good many bloody fights over it, there is no doubt about that; but it must come, and we want it to come about with credit to ourselves.



We are not going to surrender. That is not the idea at all. They ask us to come in, and to practice just exactly as we have been practicing—not to give up anything whatsoever. I asked the president of their State Society what would be the situation if a number of homœopathic physicians were to join their State Society and go before that body and relate cases cured by homœopathic remedies, should they be listened to? He said, "You certainly would. I can't tell you how you would be received. Those things must be worked out little by little. There would be those who would object to it, no doubt, but your independence and your intelligence certainly must make itself felt in time,"—and it will. So, I say, this thing has got to come about; we cannot stop it—we want to meet it half way; but in whatever way it comes we are not going to surrender. (Applause.)

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# PRIMARY COLLOID CANCER OF THE OMENTUM WITH THE REPORT OF CASE COMPLICATED WITH PULMONARY TUBERCULOSIS, CIRRHOSIS OF THE LIVER AND NEPHRITIS.

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The rarity of primary cancer of the peritoneal structures and the difficulties which frequently attend its recognition seem to warrant the assumption that each occurrence of the lesion, when confirmed by post-mortem examination, is of clinical value. Any variety of cancerous growth may occur, but the colloid favors the omentum.

When associated as a secondary affection with malignant disease in some other organ, which is its usual formation, the diagnosis may be free from difficulty, especially if the neoplasm is not colloid in type. The peritoneum, under these conditions, will usually be covered with a number of small, rounded tumors scattered over its surface. Sometimes these bodies will be very small, assuming a miliary type, while in other cases they may be large with puckered or constricted centers. Colloid cancer of the omentum may sometimes attain great size. In the case under discussion its growth was small.

The clinical manifestations are usually those of progressive emaciation, sometimes fever, diarrhœa, pain or tenderness, but these symptoms may be absent and the case present, as far as the abdomen is concerned, especially if complicated with cirrhosis of the liver, the appearance of ordinary ascites.

The physical signs which essentially belong to peritoneal cancer are enlargement of the abdomen, either uniform or asymmetrical, usually the latter; stretching rather than eversion of the umbilicus

and the sensation on palpation of a firm yet somewhat yielding mass within the abdomen. Percussion may show more or less localized dullness. As a rule, change of position will have little effect upon these signs. Aspiration may reveal simply serum tinged with blood, and in the case of the colloid variety a slimy gelatinous fluid. Irregular nodules or the curled-up omentum may be felt lying across the upper part of the abdomen. This tumefaction may also be present in tuberculous peritonitis of the chronic proliferative variety, and is, therefore, of no real diagnostic value as far as differentiation is concerned.

The condition with which carcinoma of the omentum is most likely to be confounded is obviously tuberculous peritonitis. The main points of difference are as follows: Cancer is characterized by appearance in middle life and usually by the presence of multiple nodules observable on palpation, unless colloid, when a firm, yet yielding tumefaction may sometimes be recognized. Tuberculous peritonitis, on the other hand, may be distinguished by the fact that it occurs among the young and by the absence of nodules. Furthermore, the presence of an indurated mass above the umbilicus is common in cancer, while it is always absent in tuberculous peritonitis. Again, the presence of inflammation and discharge of pus from the umbilicus points to tuberculous peritonitis, as it is otherwise seldom observed. In both cancer and tuberculosis the fluid withdrawn on aspiration may be bloody.

The history of the following case was prepared by Dr. R. E. Mitchell, of the House Staff of the Metropolitan Hospital, Department of Public Charities, New York: The patient, a male, laborer, aged 35 years, was admitted to the hospital March 18, 1902, with the history of syphilis, gonorrhœa, and the use of alcohol and tobacco in moderation, aside from these he had enjoyed apparent good health until about eight months ago when he had pleurisy on the right side. Aspiration was performed and a considerable amount of fluid withdrawn. From this time his general health began to decline. There was more or less constant cough, expectoration, hæmoptysis, night sweats, dyspnœa and the usual phenomena which characterize pulmonary tuberculosis. He suffered; in addition, with a peculiar weakness of the lower extremities which rendered walking difficult.

Physical examination showed general emaciation and involvement of the upper portions of both lungs, as evidenced by their retracted condition and the presence of subcrepitant rales. The heart was normal except that there was intensification of the second pulmonic sound, as would be expected in such a condition of the lungs. The abdomen was slightly distended and contained a small quantity of fluid. The area of liver dullness was slightly lessened and there was considerable pain in the region of the liver. The knee jerk was absent. Romberg's sign was marked. The sputum showed the presence of tubercle bacilli. Examination of the urine was negative.

The patient was able to go about the ward for the first few days after, but the cough became so excessive and the weakness so pronounced that he was put to bed. The abdomen gradually became



more distended and the legs œdematous. Ten days later the distention became excessive, the dyspnœa urgent, cyanosis pronounced and danger of collapse imminent. A hundredth of a grain of atropin was administered hypodermatically and the abdomen aspirated; ninety-six ounces of bloody serum were removed. This procedure was followed by relief.

Upon examination after aspiration a roundish tumor mass could be determined extending from the epigastrium downward and to the right around to the iliac region. There was still evidently some fluid in the abdomen. The relief afforded by the aspiration was sustained only for a few days when fluid began to accumulate again and the distressing symptoms of dyspnœa reappeared.

The patient continued to fail steadily. The temperature being that of typical tuberculosis, the dyspnœa, cyanosis, and cough were excessive. The tuberculosis process extended rapidly, involving the whole left lung and greater portion of the right.

A second attempt to aspirate was made and but eight ounces of bloody fluid were removed. Failing in this, salines and diuretics were given with the hope of relieving the accumulation. Heroin and morphine were used to check the cough and allow a little sleep. Whiskey and atropin were used as heart stimulants. A large amount of milk and water was administered and the urine record was rather high. At no time were there signs of renal difficulty. The salines produced copious evacuations, but all treatment seemed to be of no avail. The abdomen became more and more distended and on April 11th a third attempt to aspirate was made and but two ounces of bloody fluid removed. This was so thick that it clotted in the canula.

The diagnosis was pulmonary tuberculosis, cirrhosis of the liver, possible locomotor ataxia, and, because of the tumor-like mass and the gelatinous bloody fluid, a malignant growth in the abdominal cavity. On the next day, April 12, 1902, the patient died. The following is the report of the autopsy:

Brain normal; heart and pericardium normal; lungs and pleura, seventy-five ounces of bloody serum in the right pleural cavity. The right lung was adherent at the apex to the chest wall; the upper lobes showed marked tubercular degenerations, the lower lobes were flabby and collapsed. Eight ounces of bloody serum was found in the left pleural cavity. The left lung was adherent to the chest wall (whole outer surface) and the base to the diaphragm. The upper left lobe showed the same morbid tubercular process as the right did. The lower lobe was slightly compressed. The abdomen was filled with bloody fluid, about four quarts. The great omentum was greatly thickened (being about one inch), reddish and spongy, and was hanging down in front of the viscera, like a broad curtain, into the pelvic cavity. Subsequent microscopic examination revealed the presence of extensive colloid degeneration. It was firmly adherent to the parietal peritoneum in the right iliac fossa. The appendix was normal. The loops of intestine and all abdominal viscera were massed together with a recent exudate. The liver was adherent to

the diaphragm by its entire convex surface. Weight four pounds, marked evidences of cirrhosis. The spleen was much enlarged and congested; weight seven and a half ounces. The kidneys were large, weighing six and seven ounces. The capsule was adherent in places and the cortical markings were obscure in a few places.

Diagnosis. Colloid cancer of omentum, phthisis pulmonalis, cirrhosis of liver, nephritis.

The principal point of interest in the case is the colloid growth, which was confined to the omentum. Careful search failed to reveal a primary growth along the alimentary tract or in the adjacent organs. Its rapid development accompanied by the bloody ascitic fluid and marked cachexia are noteworthy.

The patient entered the hospital to receive treatment for phthisis. He had never had the slightest abdominal symptoms and had noticed the slight swelling of the abdomen which he presented upon entrance but a few days before. In a little more than three weeks he was dead.

The history of the tubercular process is a fairly typical one, beginning as it did, with a pleurisy and effusion of some eight months before. It emphasizes the care which should be used in the treatment of such pleurisies.

The cirrhosis of the liver and the nephritis were probably the result of the too free use of alcoholic liquors.

The diagnosis of locomotor ataxia was not fully confirmed by examination of the cord, but it seemed with the symptoms presented, together with the history of syphilis, as if this trouble might also be added to the sum total of diseases which were destined to play a greater or lesser part in the death of this patient.

The writer recalls another case of what appeared to be primary malignant disease of the omentum, seen in consultation. It consisted of a large, smooth, indurated mass, somewhat movable, situated in the left hypochondriac region and extending diagonally for about three inches across the abdomen toward the umbilical region. There were no evidences or manifestations of symptoms pointing to malignant disease elsewhere. The patient, an elderly lady, died of inanition. There was no autopsy.

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## A NEW METHOD OF OUTLINING THE SEPARATE CAVITIES OF THE HEART.

GEORGE F. LAIDLAW, M. D.,
NEW YORK.

The method which I shall recommend is not new in the sense of being newly discovered but it is new in the sense of being little known in this country and not widely accepted in any other.



Bianchi and Bozzi devised the phonendoscope in 1896 and the instrument made its way quickly over the world as a substitute for the ordinary stethoscope in auscultation; but Bianchi's method of outlining the internal organs by scratching the skin is still largely ignored. It is a refined variety of the old auscultatory percussion.

In 1900, at the Congress fur Innere Medicin, at Wiesbaden, Dr. A. Smith, of Marourg am Bodensee, reported his observations, confirming the value of the Bianchi method as applied to the heart. He also pointed out several defects in the method, described an improved technique, and an improved phonendoscope by which the most exact measurements could be made during life, not only of the heart, as a whole, but also of the auricles and ventricles separately, a thing never attempted by any other method of examination.

After a thorough trial of this method at the Metropolitan Hospital in New York, I can recommend it strongly to your attention as one of the most useful methods of examining the heart which has been devised since the adoption of auscultation itself. In proof of this statement I ask you to look at these outlines of hearts, which were drawn on the skins of the patients' chests, and compare them with the hearts themselves, which were subsequently removed at autopsy. The outlines were made on the dead body immediately before the autopsy so that there should be no possibility of change in size or position before they could be verified. These outlines are the original direct impressions. By comparing the measurements of the hearts, and even of the separate auricles and ventricles, you will see how accurately the work was done.

(Exhibition of the hearts and outlines.)

The method by which this work was done is simple and the instruments are inexpensive, a phonendoscope, a bristle brush and a pencil for marking the skin. These are the imported pencils, called dermatographs, but this ordinary indelible pencil gives better prints. This is the bristle brush devised by Smith, but as an interne of the hospital suggested, a mucilage brush will do as well. It should be stiff.

The rod of the phonendoscope is placed over the right ventricle, which can be found in the fourth intercostal space at the left of the sternum. With a stiff brush or the finger tip, the skin of the chest is stroked firmly downward toward the lower border of the heart. A brushing noise is heard. When the border of the heart is passed the sound changes abruptly. This point is marked with the pencil and, placing the rod of the instrument above the mark, the border is verified by careful stroking. This border determined, the rod is held at the same point, just above the lower border and the brush is stroked outward to determine the left border, then upward and then to the right around to the starting place. By marking the places where the sound changes, an outline of the right ventricle is drawn on the chest wall.

Placing the rod in an intercostal space above the margin of the right ventricle, the left ventricle is mapped out in the same manner.

Placing the rod at the right of the right ventricle, the right auricle and above this the left auricle is mapped out.

The left auricle is more difficult to outline than the other cavities, both because it lies deeper in the chest and because most of it lies behind the sternum and the resonance of the bone is confused with that of the auricle. To overcome this difficulty, Wallach, of Cassell, Germany, devised this improved phonendoscope. The improvements consist in the valve, the opening of which makes the brushing noise more distinct, and in the hollowing of the rod.

This particular instrument is not a necessity. Some of these outlines that I have exhibited were not made with the phonendoscope but with a cheap imitation of it, which I now show you. It is called Simal's stethoscope and is also made in Germany. It has a hollow rod but no valve. The Bowles stethoscope, which I show for comparison, is not so convenient for this work on account of the large size of the bell, but it can be used if necessary. In fact the ordinary binaural or even the single tube stethoscope will give accurate outlines of the ventricles, but the outlining of the auricles requires the more delicate instruments. After a trial of all the more recent forms of stethoscope, I have concluded that the improved phonendoscope with the hollow rod and the valve are really the best for this method of examining the heart.

At this point, one is led to the reflection that this procedure may be very pretty and very striking, but is it of any use?

Let us consider that our ideas of diseases of the heart have undergone great changes during the past ten years. Formerly, valvular lesions and fatty hearts were the chief points in cardiac pathology. Now, the center of interest has shifted from the valvular lesion to a consideration of the diseases of the heart wall. These diseases are myocarditis and the degenerations.

In 1900, at the meeting of the American Medical Association, Dr. Solis-Cohen asserted that "the exact site and nature of the valvular lesion are of less importance therapeutically and prognostically than the state of the cardiac muscles." In the discussion which followed, this view was endorsed by all the speakers and contradicted by none.*

In the *Boston Medical and Surgical Journal* (September 16, 1901,) Dr. Robert T. Edes pleads for more recognition of the diseases of the myocardium as more important than the precise localization of valvular lesions.

In the *British Medical Journal* (January 15, 1901,) Dr. Lees describes the acute dilatation of the heart that occurs in diphtheria, influenza and rheumatic fever, with its important bearing on treatment and prognosis, and deplores the general neglect of the practice of outlining the heart by percussion.

In the *American Journal of the Medical Sciences* (August, 1901,) Professors Hare, Stengel, Finney and Mayo, in a series of papers on the effects of anæsthetics and surgical operations on the heart,

*Journal of the American Medical Association*, Jan. 12, 1901, p. 83. The Relative Importance of the Valvular and the Muscular Elements in Diseases of the Heart.



lay great stress on the fact that the dangerous element is the condition of the heart muscle and that valvular lesions are of secondary importance. In fact, in patients on whom operations are contemplated, any valvular defects present have usually been compensated.

Our own colleague, Dr. Van Den Burg, recently emphasized the need of watching the myocardium during acute diseases.*

These selections are made from recent literature at random. There are many others. I present them in corroboration of my own views.

The point of this matter of myocarditis and mycardial degeneration lies in the fact that while they are recognized partly by the character of the pulse and the general prostration, the most positive diagnostic sign is the dilatation of one or several of the cavities of the heart. That this condition of cardiac dilatation is much more frequent and extreme than was formerly supposed to be possible is readily shown by reference to recent literature. It abounds in articles like that of Dr. Lees, already quoted, showing the frequency of acute dilatation in influenza, diphtheria, typhoid fever, scarlet fever and in fact, all infectious fevers, pneumonia, inflammatory rheumatism, especially in children, hot baths, physical exhaustion, alcoholism and mental emotion.

We know that that frequent termination of so many acute diseases, heart failure, is preceded by dilatation of the cavities of the heart, one by one, with a longer or shorter period of compensation during which the pulse may be good and the only sign of a failing heart may be the dilatation of the right or left ventricle.

The detection of this dilation, then, is a matter of importance in diagnosis, prognosis and treatment, but we lack a convenient method of estimating the early degrees of cardiac dilatation. We cannot carry an X-ray outfit to the bedside, and the ordinary method of percussion is not satisfactory in the hands of the physician of average experience. Indeed, in the hands of experienced physicians, it is far from satisfactory. In the ordinary method of percussion, we recognize two outlines over the heart, the areas of superficial and of deep cardiac dullness. The area of superficial dullness is not worth much in the diagnosis of cardiac disease, as it merely indicates the extent to which the pericardium is uncovered by the lungs but not the size of the heart itself. The area of deep cardiac dullness or cardiac flatness, indicates the true size of the heart, but the correct outlining of this area is difficult. At least, R. C. Cabot, who has tried to teach it to a great many students, says that "it needs a trained ear and long practice to percuss out accurately the borders of the heart itself, especially the right and upper border."†

On page 148, "It is much more difficult to be certain of enlargement of the right ventricle than the left," and in a foot-note, "Hypertrophy of the left ventricle is often found post-mortem despite the absence of the above signs during life."

On page 149, "Epigastric pulsation gives no evidence of hyper-

*North American Journal of Homœopathy, Sept., 1901.
†Physical Diagnosis of Diseases of the Chest, 1900.

trophy of the right ventricle, despite the contrary statements of many text-books."

Sansom, in his comprehensive work, Diagnosis of Diseases of the Heart (1892, p. 154), says: "The satisfactory determination of the area of deep cardiac dullness by finger percussion only is not easy."

Dr. Musser, in his Practical Treatise on Medical Diagnosis (1899, third edition, pp. 615-618), says: "The lower border of cardiac dullness is ascertained with difficulty because of its close apposition to the liver." In the use of the pleximeter: "Vibrations over the liver and over the right ventricle are difficult to distinguish." Again, "The lower border and rounded apex of an enlarged heart cannot be defined if the stomach contains food or fluid."

The American System of Practical Medicine, edited by the late Professor A. L. Loomis and Professor Gilman Thompson (1897, vol. II, p. 336), states: "The lower border of the heart cannot be outlined except when, with gentle percussion, the tympanitic resonance of the stomach is detected through the left lobe of the liver. As a rule, we are forced to draw an imaginary line from the edge of the sternum to the apex."

Page 339, "It is impossible to map out the areas of cardiac dullness when a flat region depending on a pathological process immediately adjoins them. In complete solidification of the upper lobe of the left lung, from pneumonia, the upper and left border of cardiac flatness cannot be determined. The same is true of consolidations of the right lung and also in phthisis."

To Cabot's note of the frequent overlooking of hypertrophy of the left ventricle, add Senator's estimate that most of the cases of cardiac hypertrophy of parenchymatous-nephritis remain undiscovered during life;* the statement of Grote, of Nauheim, who ridicules the Bianchi method and advocates simple percussion, that, on outlining the heart on eleven bodies by simple percussion, he missed the left border (the easy border) in the first five of them;† the fact that Professor Stengel, in his study of the immediate and remote effects of athletics on the heart,‡ confuses the area of superficial dullness with the size of the heart and repeatedly speaks of the right border of the heart extending to the right of the sternum as evidence of hypertrophy of the right ventricle, whereas all autopsies and all anatomy books show that it extends there normally; the fact that Stengel, in the same paper, Darling, in his studies of the heart changes in Harvard athletes during their contests,§ and Schott, in his elaborate study of The Influence of Acute Over-straining of the Heart on Blood-pressure,‡‡ can give us nothing more precise than an increase in the breadth of cardiac dullness, when you consider that these men are not general practitioners picked up at random,

*Nothnagel's *Specielle Pathologie und Therapie*, Band XIX., 1, S. 222.
†*Deutsche Medicinische Wochenschrift*, Mar. 27, 1902.
‡*American Journal of the Medical Sciences*, Nov., 1899.
§*Boston Medical and Surgical Journal*, June and August, 1901.
‡‡*New York Medical Journal*, April, 1902. Also *Verhandl. des Cong. für Innere Med.*, 1900.



but experts, teachers in our best universities, you will agree with my statement that the practice of percussion, in spite of Ebstein's cardio-hepatic triangle, up to the present time, has not been an exact and reliable procedure. There is small wonder that in examining the heart the general practitioner, feeling uncertain of his ability to learn anything by percussion, usually contents himself with feeling the pulse, listening for a murmur and locating the apex beat.

This Bianchi method, however, makes him master of the situation. By giving him a simple and accurate method of measuring the heart, it enables him to study the heart practically in that best of all schools, his own practice, and enables him to estimate for himself the effect of different drugs or plans of treatment.

I am aware that the Bianchi method of examining the heart has recently undergone severe criticism by several prominent German clinicians. Grote‡‡ attacks it and the analogous methods of Reichmann, Buch and Aufrecht. Ewald attacks it. Sahli says that the noise is too loud for his ears.‡‡‡

The chief criticism is that the resonance heard with the phonendoscope does not come from the underlying organ, but merely from the skin and that it varies, not with the shape of the organ, but the degree of stretching of the skin and the proximity of the brush to the phonendoscope. This is a half truth. In using the Bianchi method, any one of you can recognize the fact that the resonance increases as the brush or finger approaches the instrument, and decreases as you move away from it; and also that the resonance varies with the stretching of the skin. I am confident that you can also recognize, as my ear certainly does, another sound that does not vary with the stretching of the skin or the proximity of the brush to the phonendoscope, but which corresponds precisely to the anatomical outline of the underlying viscus.

Where the viscus is covered by a bone, as the sternum, or ribs, or spinal column, more care is required. The bone has a resonance of its own. By placing the phonendoscope on a rib, you can follow that rib around the chest by its resonance alone without looking at it. For this reason, in outlining the heart, it is well to place the phonendoscope on an intercostal space where practicable, and where it must be placed on a bone, to note the character and limits of the resonance of the bone before drawing the hasty conclusion that any change of resonance indicates the border of the heart.

In moving from the chest to the abdomen and vice versa, there is an abrupt change of resonance at the lower border of the ribs. When you know this, you will not confuse it with the lower border of the heart or liver.

With these precautions in mind, a very little practice will enable any one of you to outline a heart, watch its change from day to day and make tracings for comparison. At least, my assistant, a second

‡‡Wie Orientiren wir uns am besten ueber die wahren Herzgrenzen? *Deutsche Med. Woch.*, Mar. 27, 1902. Answer of Reichmann, ibid, May 15. Ewald, May 15. Also Grote in the discussion of Smith's paper, *Verhandl. des Cong. fur Innere Medicin*, 1900, p. 373.
‡‡‡*Lehrbuch der Klinischer Untersuchungsmethoden*, 1902, p. 210.

year medical student, after a few trials, could outline a heart as well as I could and his outlines too were verified by autopsy.

A very good organ for practice is the liver, as its outlines are easily determined and the differences in resonance caused by the ribs are easily appreciated. Besides scratching or brushing the skin, I have found that a light, quick tap with a lead pencil, held as a drummer holds his drumstick, will bring out clear resonance and is useful to verify the outlines obtained by brushing.

I sum up my paper, then, in three sentences: First. We are coming more and more to the belief that the condition of the heart, and especially the dilatation of its cavities, is an important factor in many prevalent diseases and there is, therefore, a need for a simple and accurate method of determining the size of the heart. Second. Ordinary percussion is unsatisfactory for this purpose. Third. The Bianchi method, especially with the Wallach improved phonendoscope and the bristle brush of Smith, fully satisfies these requirements. To those who have not employed this method of examining the heart, its results are a revelation.

(Dr. Laidlaw gave a demonstration of the apparatus and methods referred to in the paper in question.)

## DISCUSSION.

W. S. MILLS: *Mr. Chairman*, I would like to say just this, that I have watched Dr. Laidlaw doing this over in the hospital, and it is a very simple matter. The difference in sound and some of the other changes, as you pass away from the outlines of the organ, are very abrupt and really quite remarkable, when you first come to practice it, and the method is something that has exceedingly great value, and it is worth any one's while to try it and become familiar with it.

PRESIDENT MOFFAT: Are there any further remarks? I would like to ask Dr. Laidlaw if he has ever tried to follow up these matters with vanad.

G. R. CRITCHLOW: I would like to ask a question about the location of the stethoscope. Do you have any definite location?

G. F. LAIDLAW: Simply over the cavity, that is all. Endeavor to locate the right ventricle, and then taking that for the left ventricle, and you don't have to draw any lines for that matter, because you can tell by your indentations.

G. R. CRITCHLOW: Do you use them all?

G. F. LAIDLAW: Use both. You can do it either by the brush or by tapping—a little drum tapping will fix it oftentimes.

G. R. CRITCHLOW: Have you tried that for the spleen?

G. F. LAIDLAW: Yes. The spleen is easy enough to percuss with the finger, however. It is not necessary to go to that trouble with the spleen. I haven't marked out the different lobes of the lungs, but the claim is that you can differentiate the different lobes of the lungs.



# TREATMENT OF TUBERCULOSIS OF THE SKIN, BONES AND JOINTS WITH THE X-RAY AND THE VIOLET RAY.

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NEW YORK.

When some five years ago Dr. Finsen, of Copenhagen, announced that by concentrating the sunlight rays on lupus vulgaris he was able to destroy the tubercle bacillus and thus cure the disease, he little knew that he had hit upon a principle of a new therapeutic agent which would, in so short a time, startle the medical profession.

I do not, in this paper, intend to make any analysis of the principles of radio-therapy, or photo-therapy, as some have called it, but I prefer the former, or to dwell at any length on the technique, as it has been written upon so much of late that it is no longer necessary, but rather to give an account of some cases of tuberculosis of the skin, bones and joints that have been successfully treated by radio-therapy.

Tubercular conditions, with the exception of lupus vulgaris, has not yet received the attention and been so thoroughly worked out regarding radio-therapy, as has the treatment of cancers, but enough has been accomplished to settle beyond all doubt the power of radio-therapy in these dreaded maladies. Indeed it does not stop here, for tuberculosis of the lungs may be, in some cases, cured by it, but of this I do not intend to speak to-day.

The sources of this radiant energy are the violet and ultra violet ray of the white light, sometimes referred to as the actinic ray as they possess actinic action, which is produced for this purpose by a powerful arc light of about 30,000 candle power, and the X-Ray. When we come to classify these two forms of radiant energy as to their respective indications in various diseases and for various purposes, I would say that after an experience in the Flower Hospital running over several months with a continuous daily clinic, I am convinced that the violet ray and ultra violet ray, are applicable only to surface diseases, that is to lupus vulgaris, and that it is of little or no use in deep-seated conditions, such as tuberculosis of the bones, joints and lungs. I make this statement knowing that some physicians and experimenters have claimed that the violet and ultra violet rays of a 30,000 candle power light is capable of penetrating the human body, as is evidenced by the actinic action produced on a sensitized photographic plate held on the side of the body opposite to the light. This fact, if indeed it is a fact, does not prove that these rays are carried in sufficient amount to destroy tubercular germs or cancerous cells, and certainly experience has proved most conclusively, at least I think it has in my hands, that if they do possess the power to penetrate the deeper seated parts of the body, it is too slight to be of any material use therapeutically. With lupus

vulgaris the action of the rays is all that can be desired. Lupus vulgaris disappears under their influence in a way that is surprising, and yet their action here is even less striking than is the action of the X-Ray.

While Finsen will ever be honored for his formation of principles and development of technique, as well as calling the profession's attention to radio-therapy, for he did not discover it, yet his treatment, that is the electric light and sunlight treatment, must give way to the more energetic and successful X-Ray.

That once-dreaded disease, lupus vulgaris, is now readily curable; in fact, I have yet to see a case that has received proper treatment with either the actinic ray or the X-Ray, that has failed to respond to it. Two cases will illustrate the efficacy of the treatment of this disease. The first was an enormously hypertrophied lupus situated over the right eye, measuring a little larger than a silver half dollar. It had been of long standing, and had been treated by internal remedies and topical applications without effect, so far as diminishing the area of the disease. Treatments were given daily with the violet and ultra violet ray, from a so-called 30,000 candle power lamp, until sixty treatments had been given, at which time the lupus had so lessened as to make its complete disappearance a certainty. This case being of a greatly hypertrophic variety exhibited a peculiarity in the process of cure. The edges at first seemed to dry, incrustate and loosen, and finally come off. This process of destruction extended through the entire diseased area, and was undoubtedly due to the destruction of the superabundance of diseased tissue, which was destroyed by robbing it of its vitality, and it was thus exfoliated. Ordinarily there are some incrustations of the apple jelly tubercles, but not so marked as in this case.

Another case of lupus which was interesting on account of the stubbornness with which it had resisted other forms of treatment, especially very heroic forms of treatment. It was on the nose of an old gentleman seventy-two years of age. It had been extirpated with the knife once, several forms of caustics had been used without effect, and once the actual cautery had been applied so thoroughly that it had gone completely through the wall, leaving a permanent opening in the side of the nose; still the lupus failed to be destroyed. Only fourteen treatments were given with the X-Ray in this case, covering a period of eight weeks, when a dry scale came off, leaving a healthy base. It has been now about one year since the case was pronounced cured, and there are no signs of its returning.

The difference in the number of treatments required to cure these two cases of tubercuolsis of the skin by the two different rays is significant, inasmuch as the greater number required to cure the one with the violet ray is typical of the experience of a much larger number of cases treated by the different forms of manifestation of the ray. Many such cases as these, if time permitted, could be reported.

A case of tuberculosis of the rib which came under my care more than a year ago, illustrates the efficacy of the X-Ray in tuberculosis of the bones. The patient had met with an accident some four years



before, in which he had sustained a severe injury in the left side of the thorax. Just the extent of this injury could not be learned from the patient, as he had a very indefinite idea of it. The wound apparently healed at first, but soon broke out again, and discharged continually for more than a year, when an operation of scraping the bone was performed. It was thought at first that this had cured the disease as the wound healed and remained healed for some months. It, however, broke out once more, and four surgeons who had been consulted regarding it, all eminent in their branch, had unanimously agreed that a tubercular condition existed, and that a section of the rib must be removed. It was immediately following these consultations that I was consulted and began the use of the X-Ray. For four weeks two treatments were given; for the next twelve weeks one treatment a week was given, making in all twenty treatments. The discharge was markedly less after the eighth treatment, and continued to decrease until the fifteenth treatment when it ceased altogether. It is now about eight months since treatments were discontinued. The wound is thoroughly healed, and there is no indications whatever of a return of the former conditions.

A case of tuberculosis of the knee joint in a young lady, twenty-three years of age, was cured most promptly and completely. Several months previous to my having seen her, pain and some swelling began in the knee joint. She was first treated for rheumatism, but as the pain and swelling increased and began to assume characteristics different from rheumatism, a surgeon was consulted who pronounced it tubercular, and advised operating at once, but as this was dissented from, Bier's treatment of placing an elastic ligature above the knee was tried. She became so tolerant to this treatment that she could endure the ligature for eight hours at a time. This, I was informed, appeared to relieve the condition at first, but it soon lost all effect and the disease apparently began progressing as before the treatment was given. At the time I first saw her, December last, the swelling was quite marked, and the joint exhibited all the characteristics of a tubercular condition. To be more certain of the diagnosis I skiographed the knee, and the negative showed all the characteristic signs of a tuberculous joint. Treatments were begun on December 24th. I was surprised at the great sensitiveness of the skin to the X-Ray, and the tendency to burn to very short exposures. This, I think, was due to the poor condition of the nutrition of the skin. Not more than three treatments a week could be given, and even with this a different side of the joint had to be exposed with each sitting. It was also found necessary to discontinue the treatment every few weeks for ten days at a time. Forty treatments were given up to May 24th. The first twelve treatments did not produce any apparent results. At the twentieth treatment the swelling was markedly decreased, and the pain had almost entirely subsided. Gradual improvement continued from this time, and after the thirty-third treatment the joint appeared well. A skiograph was taken after the fortieth treatment, and the muddy appearance on the negative between the ends of the bones, which was so

characteristic in the first negative, as it is characteristic of tubercular joints, and may be due to either infiltration or to pus, had cleared away, but the lack of definite clear-cut outlines over the bones of the joint was still noticeable.

As I have said it has not been my intention to make any remarks on the technique, or to explain every little phenomena in this treatment, as I wish to leave plenty of opportunity to ask questions, and thus stimulate a discussion, as points can be brought out more definitely in discussion than they can in a carefully worked-out paper. I, therefore, close this paper with an invitation to all to ask as many questions as they may deem necessary to their understanding.

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# REPORT

OF THE

BUREAU OF OBSTETRICS.

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## AN OLD STORY RETOLD.

J. WILLIS CANDEE, M. D.,
SYRACUSE.

In February, 1901, Mrs. Y., primipara, announced her suspicion of pregnancy. She informed me of a bad family record in regard to child bearing, including some five deaths among near relatives occurring, as it was stated, from renal complications. In addition she said she was "small", had suffered much from ovarian troubles and received considerable treatment from a competent gynæcologist. It was generally understood by her family and herself that maternity would be in her case extra hazardous and should not be undertaken. On this point her father, a retired physician, was emphatic.

The lady further declared that she had no choice as to the course to be pursued. She desired to place with me the entire responsibility and promised to do precisely as I directed, which promise, by the way, was faithfully kept.

Naturally some thinking was done. Shortly afterward the diagnosis of pregnancy became established. Pelvimetric examination showed dimensions below the average, yet not prohibitive. No obstetric obstacle was found in the pelvic organs. It was decided to tentatively allow the pregnancy to proceed, keeping the patient under close personal observation. She was fully instructed and, with one exception, throughout the case gave intelligent co-operation.



Affairs progressed normally, her general condition improving beyond all precedent. Nothing occurred to mar the record until the beginning of the ninth month when nephritis suddenly developed.

The patient, being fond of fresh air and very cool apartments, was accustomed, during the summer, to sleep closely alongside an open window. Following a prolonged hot spell came a sudden change to quite cold weather, this occurring two or three days prior to the appearance of nephritis. Mrs. Y. made no change in either windows or bed, in fact quite enjoyed the cool nights. We looked no further into etiology. This was on September 2d. She was put to bed and kept there most of the time that followed. A rigid diet was ordered, in addition to which she was directed to take each day the juice of two lemons largely diluted in water. A competent nurse was put in charge, in whose care were left emergency measures to be used in the event of an eclamptic seizure until a physician could be obtained. Preparations were also made for a hasty delivery at any time. Daily collection and testing of the total quantity of urine was instituted.

The case presented the following symptoms: nervousness, nausea, vertigo, headache made worse on lying down, pulse sixty, showing increased arterial tension. A mitral systolic murmur could be detected. Patient could not comfortably lie down but remained propped high in bed. The quantity of urine had been very small for twenty-four hours.

Prescription: gelsemium ℗ alternated with cuprum ars. 3x. Poland water, hot fomentations over kidneys, bowels to be freely opened. At a subsequent visit on the same day glonoin 3x was given in place of gels.

September 3d. Patient appeared much improved. She continued to do well on the same treatment until September 6th, when another attack of nausea, vomiting and vertigo occurred. This yielded to cocculus 3x, given as an intercurrent remedy. The quantity of urine had increased to nearly normal. On September 8th diuresis began. From that date until the 17th the quantity varied from 104 oz. to 121 oz. per diem. The patient appeared to be doing remarkably well in so far as renal conditions were concerned. Although moderate albuminuria continued, all threatenings had ceased. The fact, however, developed on trial that she would not bear much relaxation in the treatment.

Having no previous experience to guide me, I was unable to calculate the results of diuresis before delivery. In consideration of the fact that the patient was becoming anemic and debilitated, and bearing in mind her small pelvic proportions, I deemed it unwise to wait two weeks or more till full term, particularly since there now seemed to be a probability of accomplishing delivery without convulsions.

Counsel supported this opinion, hence, on the 17th I operated to induce labor. Under the usual precautions the patient was anæsthetized, the os well dilated and packed with sterile gauze. The vagina was also loosely packed. Kali phos. 3x was prescribed.

After thirty hours the packing was removed and a hot sterile douche given. On the evening of the 18th labor pains began. In the early afternoon of the 19th, progress being slow and the patient becoming exhausted, forceps were applied and the delivery of a living male child completed. The placenta, delivered by the method of Crede, was examined and thought to have been expelled intact. Severe and persistent hemorrhage followed, to control which I was finally obliged to pack the uterine cavity. Packing was removed after a few hours. Rupture of the perineum was avoided.

From the combined effects of toxemia, hemorrhage and shock, Mrs. Y. did not react satisfactorily, hence, under suggestion of counsel in the evening, she received an intravenous quart of saline solution. This had a wholesome effect.

No eclamptic complications were manifested during the labor or subsequently until evening when, during the reaction incident to saline transfusion, one convulsion occurred. There was no further trouble of that sort.

Nothing more of note transpired until the 22nd, when a chill, rise of temperature and suppression of lochia pointed to intra-uterine irritation. Curettement secured the final installment of placenta. After this came pelvic pain and tenderness for two or three days, suggesting trouble with the tubes, but these symptoms subsided without additional complications or sequellæ. The kidneys rapidly cleared up and the patient made a good recovery.

This case may, to some of my hearers, present nothing new, but it was for myself a unique experience, the special feature being diuresis preceding delivery. Accustomed as we are, in such cases, to this phenomenon beginning in the first to the third day after child-birth, we consider that it marks the termination of the period of imminent danger and the beginning of a process which, if properly managed, leads to restoration of the kidneys.

I had never, heretofore, been able to accomplish this result in the antepartum state. What would have been the further course of the renal complication and what the ultimate developments and consequences had the pregnancy not been terminated are questions that might have been followed with interest. Just how to account for the diuresis is another consideration. It will be observed that our classical mercurius corr. was conspicuously absent. Homœopathic indications governed the selection of glonoin which was, I am convinced, indispensable to the favorable results in the case. The same cannot be said for the choice of cuprum ars. Repeated tests have led me to regard this drug, as does Goodno and others, invaluable in averting eclampsia, and it was prescribed on that indication. It seems to act as a diuretic, especially in choked kidneys of the pregnant and puerperal states.

Which of the two drugs Mrs. Y. has chiefly to thank, or if the



honors are to be equally shared I cannot say, however in this instance one thinks first of glonoin. Another point against alternation, yet I dared not omit either drug. Adjuvant treatment doubtless contributed to the results and there again our equation is disturbed. Nevertheless, in this case, it seems that medication should receive full measure of credit, for response to prescribing appeared to have been prompt and certain.

Apropos of the placenta incident it may be said that this was not the first time of being deceived in regard to its complete expulsion.

Another point brought out by this experience has reference to the sudden development of nephritis at the beginning of the ninth month. In three other recent cases this complication was met at that period in gestation, each time immediately following exposure to cold under not extraordinary conditions. This would suggest the possibility of peculiar susceptibility at that time in pregnancy. It would also point to the advisability of special precaution against such accident.

This, in view of the inattention to details, dullness or indifference to self-interests—whichever it may be—that is often exhibited by women in this condition, may not be easy of accomplishment.

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## LET NATURE TAKE ITS COURSE.

L. A. MARTIN, M. D.,
BINGHAMTON.

*Mr. President, Ladies and Gentlemen:* In the mouths of all old women, many nurses, and some doctors, you will find the words of my text—

"Let Nature Take its Course."

But in the chasing after new gods and strange goddesses the course of nature has been beset with many cares, and well nigh lost in obscurity.

It was never the intent of nature to jeopardize the life of mother and offspring in populating the world.

The world has grown older, and in many ways wiser, but dystocia still exists, and with many series of complications. And for why? "He that increaseth knowledge increaseth sorrow." Mental growth has increased the size of the fœtal head. Improper food increases ossification of fœtal structures. Lack of exercise weakens abdominal muscles. Modern dress has contracted the pelvis and produced mal positions. Ignorance of nature's laws and needs brings its penalties and punishments. Delayed and painful parturition exhausts the mother mentally as well as physically, leaving her in poor condition for lactation, if not, as sometimes happens destroying the milk supply. The sooner labor can be terminated without injury to the mother the better able will she be to resume her duties of mother and wife.

The less pain and anxiety she undergoes the better the condition of the nervous system. Do everything possible before confinement, and so lessen subsequent duties.

Let nature take its course, by correcting all disturbances of the digestive tract, the urinary organs, the circulation, the nervous system and the breasts.

Correct uterine displacements and discharges, and pelvic deformity if possible. And render hemorrhages, convulsions, fainting, exhaustion, fever, puerperal mania, and phlegmasia alba dolens impossible.

Let nature take its course, by rendering labor as prompt and painless as possible, with the indicated remedy, by baths, massage, and unguents, by anæsthesia and if necessary by forceps. Always remembering that the course of nature is free from infection, and goes forward with surgical cleanliness.

The obstetrician is doing his duty only when he understands what nature is trying to do, helps her to do it, and does it best and quickest, and that help should begin as soon as pregnancy is recognized, and continue until lactation ceases.

The obstetrician's duty is not circumscribed by the accouchment. Confinement should be concluded like a cure with the indicated remedy quickly, safely and pleasantly.

The means to this end is to quote to you the key-notes of the materia medica, a knowledge of which, and of your patient, is the only solution of the problem.

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## THE ROUTINE USE OF CHLOROFORM ANÆSTHESIA.

A. R. GRANT, M. D.,
UTICA.

Other things being equal if the accoucher can lessen the pain of labor, especially at the most agonizing period, he will be in greater demand than the midwife, who waits and trusts in nature for a successful delivery. Let it be taught that chloroform has a part in the management of labor, and is to be used regularly rather than occasionally.

The importance of chloroform in the lying-in chamber is not sufficiently emphasized in the management of the latter end of the second stage especially applied to non-operative cases, both primiparæ and multiparæ.

Besides lessening pain and relaxing the vulvar outlet chloroform is a most important factor in reducing the rate of morbidity, which surely deserves consideration. We fully believe chloroform to be the most important measure to-day of preventing the large percentage of pelvic diseases due to torn perinei, and that its routine use followed by a prescribed Sims' position during the puerperium will give a far greater proportion of strong, healthy mothers.



An intangible fear has prevented many from using an agent of great good that has comparatively no dangers.

Spinal anæsthesia is impracticable except for exceptional cases and has not been accepted by the profession.

Chloroform is more conveniently administered than ether, is less bulky and pleasanter to take and is to be preferred in all cases where obstetrical narcosis is desired, and in all short forceps cases, reserving ether for administration in prolonged operations.

Contraindications are few. Emphysema and syncope are mentioned by Bacon, but moderate administrations may be safely attempted in acute diseases of air passages, kidney diseases, and even valvular heart disease. Very rarely death follows from varo-motor or respiratory paralysis. Very, very rarely through great feebleness of heart muscle in cardiac dilatation, and in these cases only when used to surgical degree.

Westermarck's elaborate experiments proved a slight lengthening of labor under complete chloroform narcosis, but he agrees with Bukovoemski that chloroform is not injurious to mother or child.

As to post partum hemorrhage occurring after the use of chloroform, all reports seem to prove that flooding may happen in cases where its use has been prolonged to an hour or more to the surgical degree. If the rule of giving ether in procedures lasting over one-half hour is followed and if chloral is used (1 drachm in three doses of twenty drops each fifteen minutes apart) to relieve excessive pain in first stage and the beginning of second stage, we believe no such conditions will be charged to chloroform.

*Method of Administering.* In high forceps cases, in versions and other operations where complete relaxation is desired, a skilled assistant should control the anæsthetic.

It is, however, in that very large class of non-operative or normal cases where a monthly nurse or a good neighbor is the assistant, and where there have been good pains and a reasonable progress, that the use of this narcotic may be practicably used to great advantage.

If the woman be delivered in the Dorsal position, as is customary in this section, the accoucher seats himself facing the patient with his right sterile finger tips upon the advancing head. He directs the nurse to sit at the patient's head with directions for applying and removing the Esmarck inhaler during and between pains, the physician dropping the chloroform himself with the left hand, and so easing the severity of the pains until the moment when the head bulges the perineum, when he pushes the anæsthetic to the stage of complete relaxation for a few moments only, but sufficient to deliver the head with or without the aid of the rectal finger—insuring an intact perineum.

The following case history may be of general interest to the obstetrician and offers some clinical proof of the freedom with which chloroform may be administered to a parturient with valvular heart disease. Aortic, systolic mumur at the base Justo minor pelvis, 3¼". Age, 29. Family and personal history good. Menstruated first at fourteen, and normally.

First labor in 1897. Severe instrumental child born dead.

In 1898, at what seemed to be full term, had regular five-minute labor pains for forty-eight hours with no dilatation of cervix. Head not engaged. Chloroformed but unable to apply forceps, head not engaging and cervical dilatation being insufficient; performed podalic version, and though we delivered in four minutes, child never breathed.

In 1899 performed trachelorraphy and perineorraphy to cure a pronounced sexual neuræsthenia, chloroform and oxygen being used as the narcotic, the patient collapsing on table from respiratory paralysis and only revived after a half hour of active efforts. The neuræsthenia, with its multitudinous symptoms, was completely cured, however.

In 1900 this patient believed herself pregnant and for nine months was a most beautiful illustration of pseudo-cyesis, every symptom even to breast milk, abdominal enlargement and stopping of menses being present, but no child at term.

On June 5, 1902, regular intermittent pains began in what this remarkable woman believed to be true labor, for though we knew her to be pregnant this time we calculated August 5th to 10th. The os was rigid, however, and five grains of valerian every two hours for a few doses quieted these false contractions. She continued to have these rythmic pains almost daily and at times every three or four minutes for hours, until August 27th, when tired out by two nights of constant pain sent her to Homœopathic Hospital, where we passed a bougie six inches into uterus between head and membranes and packed vagina. After twenty-four hours no additional pains but dilatation of one finger. Withdrew packing and passed bougie on opposite side of uterus and left twenty-four hours with two fingers dilatation.

Then gave chloroform to surgical degree and passed Barnes' bag through cervix and pumped in twelve oz. sterile water. Within one hour of coming out of chloroform strong pains expelled Barnes' bag but head still high and membranes intact. After waiting four hours and getting no descent of head applied high forceps under complete chloroform anæsthesia and delivered alive six-pound boy with very large head. After waiting one hour, during the latter part of which uterine manipulation and Crede was practiced, introduced sterile hand and peeled placenta from fundus. Intra-uterine douche and ergot administered, mother and child doing well.

CONCLUSIONS.

1st. All obstetrical cases may and should have anæsthesia.

2nd. Chloroform is indicated in the last one-half of second stage. Chloral in first stage and first half of second stage when necessary to relieve excessive pains. The use of ether to be confined to long operations.

3rd. The routine administration of chloroform elevates the status of the accoucher and markedly decreases the rate of morbidity without sacrificing the mortality rate, immediate nor distant.

# APPENDIX.



# Necrologist's Report.

## CHARLES LEWIS BONNELL, A. M., M. D.

BY H. C. VAN BUREN, M. D.

(*From The Brooklyn Eagle.*)

Charles Lewis Bonnell, A. M., M. D., who died at 3 Hanson Place, January 15, 1902, was born in Brooklyn, October 15, 1846.

His father, Nathaniel Bonnell, came to Brooklyn in 1827, though the family, which was Flemish, settled in New Jersey. On the maternal side he was the grandson of the distinguished Shepard Lewis, whose connection with Brooklyn dates back to Revolutionary days when it was a village.

Dr. Bonnell received his academic education in Brooklyn, and then entered Wesleyan University, from which he graduated and received the degree of A. B. with the class of '68.

In 1871 he received the degree of A. M. from his Alma Mater.

He joined the Eclectic Society upon entering college, among whose members are some of Wesleyan's most prominent alumni, and at his graduation won high honors, and was elected a member of the Phi Beta Kappa Society.

He obtained his M. D. from the Hahnemann Medical College of Philadelphia in 1871, after two years of preliminary study in the College of Physicians and Surgeons in New York City, and began practice in 1872.

Dr. Bonnell was visiting surgeon and lecturer at the Brooklyn Homœopathic Hospital and for six years chief of staff.

He was also a member of the staff of the Brooklyn Maternity for several years, where he was also a lecturer. He was consulting surgeon and lecturer to the Memorial Hospital for Women and Children. He was a member of the New York State Homœopathic Society, and of Kings County Homœopathic Medical Society, of which he had been president for two terms.

He was for twelve years a director of the Brooklyn Young Men's Christian Association, in which organization he was very active in advancing its educational work.

He was prominently connected with the Hanson Place Methodist Episcopal Church and had been secretary of its board of trustees for eighteen years.

He was a member of the Montauk Club, and the Phi Beta Kappa Society of New York.

On both sides his family has long been identified with Brooklyn, where he spent practically his whole life and was equally well known in social and professional circles. He was a skillful physician and surgeon, a loyal friend and an honorable man.

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## HENRY VON MUSITS, M. D.

By J. W. DOWLING, M. D.

Dr. Henry Von Musits died March 24, 1901, aged 63 years. He was graduated from the New York Homœopathic Medical College in 1878. He was a member of the New York State Homœopathic Medical Society, the American Institute, the New York Homœopathic Materia Medica Society, and the County Homœopathic Society, also the Academy of Pathological Science. He was also commissioner and examiner in lunacy.

Some fifteen years ago he developed a chronic form of phthisis which made his life one long struggle. Still by care and watchfulness he was able to keep up almost to the end. He was an earnest and faithful follower of Hahnemann, whose teachings he believed



inspired, and prescribing only the single remedy in a high potency, accomplished results often remarkable and astonishing. In temperament he was genial, warm hearted and kindly, with a large practice among the poor, from which the only return was gratitude.

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## HENRY FOSTER, M. D.

By C. C. THAYER, M. D.

A BIOGRAPHY IS EASIER WRITTEN THAN MADE.

A biography of Dr. Foster was never written save on the hearts of his fellows as they perchance have come under the benign influence of his personality, or of the institution known as the Clifton Springs Sanitarium, situated in Clifton Springs, in Central New York.

Henry Foster was born in Thetford, Vermont, January 18, 1821. His father was a farmer and miller. He began his medical study in Lowell, Mass., and graduated from the medical department of the Western Reserve College, 1844. "While in Lowell," said he, "I cared for a sick brother who was being treated in a so-called 'water cure'. While there, though bred an allopathist and strongly attached to the faith, a revelation came to me, that this kind of treatment was best for chronic troubles. Wishing to know more about this system, in 1847 I found myself at the head of the medical department of the Water Cure, in New Græffenberg, New York. During my three years' stay there I accumulated $1,000, and a valuable stock of experience."

He had several opportunities to manage or build like institutions, one in Cincinnati, one in Western New York, one in Connecticut, but as he early consecrated himself and all his gifts to his Heavenly Father, his first inquiry was, "What saith the Lord?" "In this," said he, "I earnestly sought the Lord's will, and was finally led to the little village of Clifton Springs in 1850. The place had already a reputation for its beautiful and plenteous white sulphur water. I felt sure that God had sent me here, and I purchased a little cottage and ten acres of land surrounding the springs, and began, in this humble way, my hard and trying life work. God raised up friends who sent me, one, five hundred dollars, another, four hundred, another, three hundred, and so on till I had twenty-three hundred dollars to put into a new building. Now, many professional competitors and carpers rose against me and the new system, till days grew dark and experience bitter. This, I now think, was for a purpose, that I might take God into partnership and crown him Lord of all in my business. So bitter and scheming were my enemies, that had it not been for a personal assurance vouchsafed to me from my Heavenly Father as my guarantee I never could have endured.

One night, when weary and heavy laden, and I had long besought him for deliverance, he showed me my life work which I could not take in at first, yet so clear and positive was it, that from that hour

it became the plan and purpose of my life, and though many times since burdens were so heavy that all nights and days were spent in prayer, yet neither my faith or purpose has ever wavered." Daily religious services were held in the "Cure" from the first, when divine help was invoked to save, to guide, and to heal both soul and body.

In 1856 a brick chapel was added to the "Cure", and dedicated July 28th. By this time fifteen other additions had been erected. In 1873 the annex was put up on the opposite side of the street, two hundred and twenty feet front, with nine stores on the ground floor, sixty rooms for patients, and three stories high. In 1876 the Y. M. C. A. wing to the annex was put up, seventy feet long, with a beautiful public hall, library, parlors, etc., which was turned over to that body, and was the first gift of that kind in the history of the association. In 1889 an addition of thirty feet, fireproof, was added to the annex, four stories high, with forty rooms for patients, and a beautiful operating room with hospital equipment on the top floor, making the annex three hundred and eighteen feet long.

In 1880 Mr. Andrew Peirce, as a thank-offering for the remarkable cure effected in his family, erected beautiful cedar pavilions over the springs and other improvements to the cost of $15,000.

In 1890, Dr. Foster erected the "Tabernacle" with cedar frame and glass sides for the meetings of the "International Missionary Union", conventions, summer schools, etc., at a cost of $2,200.

In 1893 the rebuilding of the Sanitarium was begun. Three previous buildings with increasing capacity had been put up, but none of them met the "pattern he had seen in the Mount years before". One-half was completed in 1894. In 1896 the entire building was finished, two hundred and fifty-two feet long, fireproof, six stories, with solarium enclosed in glass, and with a wing sixty-five feet in length and same height of main building, in which is an elegant chapel, with pipe organ, two full height memorial windows, and a beautiful mosaic of the "Lord's Supper", the latter the gift of Mr. M. M. Buck at a cost of $5,000. Regular union religious services are conducted by a settled chaplain every Sunday and during the week, and also Dr. Foster's Bible Class, carried on from the first, and now led by one of the physicians.

There is a large reading room with one hundred leading papers and magazines, and four thousand volumes of books. The institution is equipped with electric dynamos for lighting, medical services, etc., with gas, ice and sterilizing water plants, commodious offices for the ten physicians, and the most elegant and extensive bathing departments with hydro-therapeutic equipment in the land. There are also gymnasium, bowling alley, golf links and tennis court, and the original ten acres have now become a delightful park of sixty-five acres.

There are also a chartered training school for nurses with thirty-five pupils, and a farm of four hundred acres with two hundred and fifty head of blooded cattle, furnishing most delicious milk, cream, and butter, and from three to five hundred hogs.



In 1881, Dr. and Mrs. Foster, by deed of trust and act of legislature, transferred the entire property to a board of trustees consisting of fourteen leading men in church, law, and business, including three bishops and the supreme court judge to look after its interests, and perpetuate its usefulness.

Early in the history of the Sanitarium, Dr. Foster proposed to treat gratis all ministers of the gospel, regular school teachers and missionaries; which treatment, some years, has amounted to over $30,000, which, with other benefactions, has spread his generous and gracious benefits to many lands.

He was a Methodist in religion, Republican in politics, and temperance in principles, but would hold no office. "One thing I do" was his motto. He marshalled all his forces to ameliorate human suffering, and elevate the race, and his words and works bear testimony to both young and old of noblest manhood.

He had no children. Two sisters and one brother survive him, aged respectively eighty-five, eighty-seven and eighty-nine years. His surviving widow, revered and loved by all, is nobly acting as superintendent of the sanitarium in place of her departed husband.

Dr. Foster was married in 1872 to Miss Mary E. Edwards, descendant of Jonathan Edwards. Their humble cottage stands on the grounds, where he lived till his death, which occurred January 15th, 1901, and his funeral was on the anniversary of his eightieth birthday, and was conducted by the chaplain, Rev. S. H. Adams, D. D., assisted by several other notable persons from different parts of the country.

The accompanying poem, which was prepared for his birthday anniversary, not expecting his death, was requested to be read at his funeral:

Matt. XXV. 21.

"WELL DONE."

Well done. The books of eighty years will tell
What love divine has wrought
In thee, and through thee brought
The King a harvest rich. Thou hast done well.

Well done. The books of eighty years will tell
How love and word and pen
Have life and comfort been
To scores in every land. Thou hast done well.

Well done. The books of eighty years will tell
How every passing year,
God's love has seemed more dear,
And as you leaned, grew strong. Thou hast done well.

Well done. The books of eighty years will tell
Of leading all the way,
Of mercy every day,
For thou hast "walked with God". Thou hast done well.

Well done. Good and faithful. Thy King will see
Thy ransomed soul set free,
His gifts doubled in thee,
He cometh beloved, He cometh for thee.

C. C. THAYER, M. D.

He was buried in the village cemetery. Truly, Dr. Foster was a good and great man. Always seeking God's will, possessing enviable business sagacity and professional skill, his life and success was a striking illustration of the power of Christian faith as a practical and profitable factor in business activity.

For several years Dr. Foster had suffered from organic heart trouble. In October he suddenly grew worse, became very low, yet again rallied and planned to go to Florida February 5th, where he had been going for twenty-five years, and where he had a pleasant home and extensive orange groves. But on the morning of January 15th, after a fairly good night, and he had taken his morning bath, and while sitting yet undressed, he was found breathing his last, and like Stephen, looking up to Heaven with a glorified radiance on his face as if just meeting the celestials who had come to escort him home.

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## DR. GEORGE H. CHURCH.

By N. B. COVERT, M. D.

George H. Church was born in the town of Phelps, Ontario County, N. Y., and died in Geneva, N. Y., March 30, 1902, aged 61 years. He commenced the study of medicine after he was married and under adverse circumstances. He attended lectures for two years at Ann Arbor, Mich., but never received the degree of M. D. He was licensed to practice by the board of censors of the Ontario County Homœopathic Medical Society.

He did good work in his humble sphere and he was appreciated in the community at Oak Corners, N. Y., where he resided.

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## HENRY MITCHELL SMITH, M. D.

By A. WORRALL PALMER, M. D.

Henry Mitchell Smith, M. D., son of Dr. John T. and Amelia Franklin Smith, was born in New York City April 24, 1835, in which city he always resided.

His early education was obtained at Friends' Seminary and another private preparatory school and he finally graduated from New York Homœopathic Medical College in 1860. In 1859 he married Jennie V. Wright, of New York, who died six years later. In 1867 he married Mary E. Moorehouse, who survives him.

He was one of the most active men our fraternity has had the fortune of including in it, as evidenced by the following. While in medical college in 1858 he assisted Drs. Wells and Dunham in editing "The American Homœopathic Review". Upon graduation he joined the American Institute of Homœopathy and was immediately elected provisional secretary. The following year he became



a member of the New York County Homœopathic Medical Society and was at once made secretary, holding that office eleven years. Also a member of Hahnemann Academy of Medicine. In 1865 he joined this State Society. In 1865-66 he was professor of physiology in the New York Medical College for Women and the three succeeding years held the same chair in the New York Medical College. Throughout almost his entire career he conducted the pharmacy founded by his father in 1844 and which bears their name.

In his early career he edited the first directory of homœopathic physicians in the United States.

He made a bibliographical index of the American Institute of Homœopathy. Of the committee on the pharmacopœia of the American Institute, with possibly the exception of the secretary, he was one of the most active editors of our present pharmacopœias. At the time of his death he was compiling a complete general index of the Transactions of the American Institute of Homœopathy, an indefatigable, self-imposed task, and for ten years before his demise held the office of necrologist of the institute. But the undertaking which has made him known not only to the profession, but the laity as well, and that which has brought him near to the heart of every homœopath, was his untiring work for the erection of the Hahnemann monument. His labors in this direction gave him the familiar name of "Hahnemann Monument Smith". Throughout life his connection with each and every enterprise showed that whatever he attempted, he went into it with a will and energy which was bound to make it a success. A man of true worth and strong character.

The last few years of his life he suffered from heart disease, probably due to some of his energetic labors for the homœopathic cause, and finally died in California of pneumonia on March 16, 1901.

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## GEORGE H. DOTY, M. D.

By EDWARD W. AVERY, M. D.

Dr. George H. Doty was the son of Joseph and Augusta Doty, of Netherwood, Dutchess County, N. Y., and was born on a farm April 21, 1860, in Pleasant Valley, Dutchess County, N. Y. He attended the county school until he was prepared to take a more advanced course, when he entered the school of Dr. Pelham in Poughkeepsie, N. Y. He remained here till he was prepared to take a course in medicine, when he matriculated at the New York Homœopathic Medical College, graduating thence in the spring of 1884. He at once entered the Brooklyn Maternity Hospital as interne and acted in that capacity till the fall of 1891, showing during that time a marked degree of skill, tact and gentlemanly bearing. It was my good fortune to come in contact with Dr. Doty during his incumbency as interne of the hospital every few days, and while he was practicing his profession in the city of Brooklyn I met him frequently, both socially and professionally.

The traits that distinguished him for excellence were modesty, earnestness and manliness. He was early distinguished for his lovable disposition and ingenuous nature. He was a favorite with both teacher and scholar, and manifested a modest disposition and a thoughtful and enquiring mind. His great love for his mother was remarked by all of his intimate friends.

Dr. Doty was of a rather delicate organization. The painstaking devotion to his profession not unfrequently overtaxed his powers and constrained him to take a rest from exacting duties. The cause of Dr. Doty's death was typhoid fever, which manifested itself last Thanksgiving Day, on which day he was in the active pursuit of his profession though in a debilitated condition. He died on the 5th day of January, 1902, in the city of Brooklyn from profuse intestinal hemorrhage. About one week previous he had a relapse after giving decided indications of convalescence. Naturally of a nervous tendency he was abnormally sensitive about his condition, which may have contributed to his demise.

The doctor never married. His father and mother are the only surviving members of his family.

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## WILLIAM TOD HELMUTH, M. D., LL. D.

By W. H. BISHOP, M. D.

William Tod Helmuth, M. D., LL. D., died suddenly at his residence in New York, May 14, 1902. Dr. Helmuth was born in Philadelphia, October 30, 1833, his ancestors coming from the Dutchy of Brunswick. He received his early education under the late well known author, James Pastor, and then completed his college training to the senior year at St. Timothy's College, near Baltimore. In 1850 he commenced the study of medicine with his uncle, Dr. W. S. Helmuth, a professor in the Hahnemann Medical College of Philadelphia, and graduated from that institution in the class of 1853.

In 1855 he was elected professor of anatomy in the same college and during the year published a work entitled, "Surgery and its Adaptation to Homœopathic Practice," which was followed in 1873 by the first edition of his "System of Surgery", the latter work having passed through five editions. In 1858 he removed to St. Louis, and shortly after became one of the founders of the Homœopathic Medical College of Missouri, in which institution he occupied the chair of anatomy. In 1869 he organized the St. Louis Homœopathic College of Physician and Surgeons, and became its dean and professor of surgery. While in St. Louis, Dr. Helmuth was one of the surgeons of the Good Samaritan Hospital, and in this position had a large experience during the Civil War.

In 1870 he was called to New York to accept the chair of surgery in the New York Homœopathic Medical College. Upon the eve of his departure from St. Louis the faculty and his numerus friends presented him with a handsome silver service.



Dr. Helmuth's love for surgery developed early in his student days, and his first operation was performed before his own class upon a patient brought into the amphitheatre during the absence of the operator. For this he was severely reprimanded by the faculty. The facilities for the study of anatomy and surgery in St. Louis were most limited, so Dr. Helmuth fitted up the upper part of his stable for a private dissecting room where he lectured before a small class of students. He also maintained a number of rooms near his residence where he operated and took care of his patients free of charge, and in some instances paying the patients for the privilege of operating upon some interesting conditions.

Dr. Helmuth was always deeply interested in hospital work and was largely instrumental in establishing the Hahnemann Hospital in New York. He acted as one of its surgeons for a number of years and at the time of his death was on the consulting staff. When the Flower Hospital was built in 1890, he organized the service and remained its chief consulting surgeon. He was also consulting surgeon to the Laura Franklin Hospital for Children, New York Homœopathic College and Hospital for Women. About this time he was elected Dean of the New York Homœopathic College and Hospital, and successfully conducted the institution until the termination of his life.

While in New York, Dr. Helmuth also conducted a large private hospital for the exclusive care of surgical cases, where he was assisted by his son, Dr. W. T. Helmuth, Jr., and Dr. William H. Bishop. The reports of this institution contain cases of universal surgical interest.

Dr. Helmuth was a member of the American Institute of Homœopathy, New York State and County Homœopathic Societies, all of which he served as president. He was also an honorary member of the Homœopathic Societies of Massachusetts, Rhode Island, Connecticut, and the National Homœopathic Societies of Great Britain and France.

The Hahnemann Medical College of San Francisco gave Dr. Helmuth its honorary degree and in 1877 the regents of the University of the State of New York conferred upon him the degree of doctor of medicine. In 1888 Yale University honored him with its LL. D.

Dr. Helmuth's fondness for verse and ability to write were shown early in life. His first attempt at twelve years of age has been followed by numerous and valuable contributions to medical and current literature, among which, exclusive of magazine articles, may be mentioned:

1855. Surgery and its Adaptation to Homœopathic Practice, 8 vo., pp. 651.
1873. A System of Surgery, 8 vo., pp. 1228. 1878. Third Edition, pp. 1000. 1879. Fourth Edition. 1887. Fifth Edition, Engravings, pp. 1111.
1861. Valedictory Address to Graduating Class of Homœopathic Medical College of Missouri, 8 vo., pp. 18. Others in 1868 and 1870.
1862. A Treatise on Diphtheria, its nature, pathology and Homœopathic treatment; Second Edition, 1864.
1866. Medical Pomposity, A Satire, 8 vo., pp. 15.
1867. Annual Address before American Institute of Homœopathy, 8 vo., pp. 40.

1867. An Essay on Cleft Palate, Illus., with lithographic plates, 8 vo., pp. 29.
1870. Ten Cases in Surgery, Illus., with lithographic plates, 8 vo., pp. 28.
1875. A Dozen Cases of Clinical Surgery.
1875. A Record of Surgical Clinics.
1876. The Influence of Homœopathy on Surgery, 8 vo., pp. 41.
1879. Scratches of a Surgeon, *Poems*, 16mo., pp. 120.
1879. The Doctor Woman, *An humorous poem.*
1879. Nerve Stretching with a short history of the operation and illustrative cases.
1880. Epicystotomy, Hypogastric Lithotomy, Suprapubic Lithotomy. The high operation for stone.
1880. A Steamer Book, being a picturesque account of a city on the sea, 18mo., pp. 142.
1882. Suprapubic lithotomy, the high operation for stone; Epicystotomy, hypogastric lithotomy. The high operation for stone, 4to, pp. 93.
1883. Present Status of Antiseptic Surgery.
1884. How I Became a Surgeon, *a poem*, 8 vo., pp. 12.
1885. Fourteen Consecutive Cases of Ovariotomy.
1885. Two Rare Cases of Exstrophy of Bladder.
1886. American Institute of Homœopathy, Bureau of Surgery, Inguinal and Femoral Herniæ.
1885. Ovarian Tumors and Ovariotomy, 8 vo., pp. 43.
1886. Alumni Poem.
1887. Humanity, *a poem*, small 4to.
1889. Sectarianism in Medicine, 8 vo., pp. 20.
1890. Homœopathy: its relation to the people and the old school.
1892. With the "Pousse Café," *A collection of Post Prandial verses*, pp. 141.
1892. A contribution to the study of Renal Surgery.
1893. A glance at Japanese medicine ancient and modern.
1896. Two views of Japan.
1898. Address at Jubilee commencement of Hahnemann Medical College of Philadelphia.

Dr. Helmuth was also co-editor of the *North American Journal of Homœopathy*, 1862-69; *New England Medical Gazette*, 1871-72; *New York Journal of Homœopathy*, 1873-4; *New York Homœopathic Times*, 1875-77; editor *Western Homœopathic Observer*, 1863-71.

Mrs. Fannie I. Helmuth, his widow, and two children, Dr. W. T. Helmuth and Mrs. W. P. Edgerton, survive him.

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## SELDEN HAINES TALCOTT, M. D.

By MAURICE C. ASHLEY, M. D.

Dr. Selden Haines Talcott was born July 7th, 1842, in Rome, Oneida County, New York. His boyhood was spent on a farm. He graduated from the Rome Academy in 1864, and soon thereafter entered Hamilton College; one month later he enlisted as a private in the Fifteenth New York Volunteer Engineers and served about one year; he was honorably discharged June 30, 1865. Returning to Hamilton College soon after the war, he resumed his studies and graduated with the class of 1869. In his junior year, Dr. Talcott was a prize speaker, and in his senior year he was one of the Clark prize orators, and also editor of the *Hamilton Campus*. The degree of Master of Arts was conferred upon him by his Alma Mater in 1874,



and the honorary degree of Doctor of Philosophy from the same college in 1882. After graduating from Hamilton he studied medicine at the New York Homœopathic College, where he graduated March 1, 1872; he was the valedictorian of his class. He then entered into partnership with Dr. E. A. Munger, of Waterville, N. Y. In 1873 he married Miss Sarah A. Munger, the daughter of his partner. In September, 1875, Dr. Talcott was elected chief of staff of the Homœopathic Hospital on Ward's Island. He also acted as medical superintendent of the New York City Asylum for Inebriates, and at one time as the medical officer of the Soldiers' Retreat in New York City.

Dr. Talcott was a member of many state and national organizations and held offices in several of them from time to time. He was president of the American Institute of Homœopathy, of the New York State Homœopathic Medical Society, of the Oneida and Orange County Homœopathic Medical Society. He was an associate member of the Royal Society of Medicine in Berlin. He held various offices of trust and honor in Middletown, where he had lived for twenty-five years.

Dr. Talcott has written many articles for medical journals which have been widely copied; he has also published numerous pamphlets on medical topics. His only book, entitled "Mental Diseases and Their Modern Treatment", was published a year ago last spring. Dr. Talcott has delivered many lectures and addresses before literary and other organizations, one of the last being a beautiful tribute to Hon. Luther R. Marsh on his 90th birthday, entitled "The Sunset of Life". For several years he was a regular lecturer on insanity in the Hahnemann Medical College in Philadelphia, Pa. During the last twenty years he was a lecturer on mental and nervous diseases in the New York Homœopathic Medical College.

In 1877, Dr. Talcott was, by the unanimous choice of the board of trustees, appointed medical superintendent of the Middletown State Homœopathic Hospital for the Insane, and on April 24th of that year his real life work began. This small, undeveloped, unorganized, unknown hospital for the insane was located at Middletown, N. Y. Dr. Talcott, in the full vigor of youth, full of energy and ambition, then and there began the work of developing what is to-day generally conceded to be the most successful and the most humane, as well as the largest, homœopathic hospital for the insane in this or in any other country.

There stands to-day in Middletown, New York, as evidence of this man's skill as a physician, of his executive ability, and of his untiring and continuous labors for the sick in mind and body, a monument—not a cold shaft of marble or granite, but an asylum for the distressed in mind—a place where they may seek seclusion, rest and restoration.

Almost under the shadow of this great hospital lies all that is mortal of this physician who has done so much to demonstrate the efficacy of homœopathy in the care and cure of the insane.

Dr. Talcott was generously endowed by nature. He had a mag-

nificent physique; he was tall, with a full chest, splendid broad shoulders, and handsome, abundant hair and beard, which had grown gray during the past two years. He was fond of the creature comforts, loved his ease, relished a good meal, a good story, a hearty laugh. A joke was always appreciated by him. Illustrative of his sense of humor being always on the alert, is the following incident of his last illness: His attending physician and the writer stood beside his bed one day after a two or three days' fast on doctor's part, while the nurse was preparing some gum arabic water for him. Dr. Talcott was then very weak, but he looked up at his nurse with the merry twinkle in his eye which we all remember so well, and said: "Thou preparest a feast before me in the presence of mine enemies." This little joke at the expense of his physicians, who had found it necessary to keep him on a very low diet, was the nearest approach to fault finding that one can recall during his four weeks' illness. There was something very touching in his submission alike to his illness and to the measures that seemed best to adopt in caring for him. It served to endear him to all who had the privilege of doing anything for him during those last days.

Dr. Talcott was a keen observer, his mind grasped quickly the salient points of a situation; he was prompt in action, though seemingly inactive; he was impatient with delays; he liked his orders carried out instantly and to the letter; he could not brook carelessness or failure. He was not so much a student of books, during his later years, as he was of men. One of his strong traits was his ability to command the loyalty and the affection of his helpers, even when they differed from him in opinions. He loved to say comforting things to persons in distress. Evidences of physical or mental pain he was keenly alive to, and he tried, in his big-hearted way, to alleviate them. He liked to feel himself useful. Let him feel that a person was looking to him, and to him only, for succor, material or otherwise, and he would tax his resources to help him. He hated to witness suffering, was easily moved to compassion, consequently a trip through the hospital wards often exhausted him even when in the possession of full physical vigor. He loved to clear away pain and the evidences of it. He loved to quiet strife and contention. He passionately longed for harmony and peace in all relations and in all persons who had to do with each other. He was very charitable concerning the mistakes of others, excepting stupidity, this was the one thing he would not tolerate and concerning which he could not conceal his impatience. The quality of mercy was not strained with him, and people often took advantage of his tolerance; it was not so much that he was blinded to their faults, as that he was merciful. Toleration for the unfortunate and forgiveness for the erring were prominent traits. In fact, those who knew him best were wont, laughingly but truthfully, to say that in order to be judged leniently by Dr. Talcott one must have committed some grievous fault, or must be convicted of some glaring weakness. The very weakness of the culprit's defence seemed to appeal to a certain chivalry in doctor's nature, and the unworthy culprit often stood a better chance than one who could defend his conduct.



Doctor's was a generous nature, as all who have known him will agree to. His annual dinners to the medical students and his quarterly trustee dinners showed his large-hearted hospitality. With what delight did he prepare the menus, and how painstaking he was to see that every order was carried out, even to its smallest detail. On Thanksgiving, and other holidays, he enjoyed going from one ward of the hospital to another and carving the turkeys and chickens for the nurses and the patients.

Endowed as he was with a large physique, possessed of a hopeful temperament, and with the strong appetites that go with this makeup, we can readily understand how these helped him to look after the physical needs of the large number of unfortunate persons entrusted to his care. He tried to build up the reduced bodies of his patients, believing that when that is accomplished much has been done toward mental restoration as well. His close attention to the material needs, food, clothes, blankets, pleasant surroundings, *et cetera*, his care concerning all of these things, were made possible just because this side of his nature was so generously endowed.

Dr. Talcott's fidelity to homœopathy is unquestioned and, I think, one may say, unrivalled, by any in our school. The Homœopathic Hospital at Middletown is not one in name only, but it has been conducted on strict homœopathic principles during Dr. Talcott's entire charge. Sometimes when young members of his staff have made suggestions and tried to persuade Dr. Talcott to let them try some vaunted remedy not strictly homœopathic, doctor would usually reply: "Homœopathy has carried us along thus far; it has been good enough for twenty-five years; I guess we will try it a while longer."

Dr. Talcott was unduly sensitive to praise and to blame. He suffered from criticism in proportion as he brightened under merited praise. His sensitiveness to criticism, even the criticism of the patients, has often been noticed. His peculiar conservative tendencies made him dread proposed changes in the management of the State hospitals. He had become accustomed to the board of managers. He was unduly apprehensive of other management, fearing that it could not possibly be so friendly. He felt himself growing too old and too tired to face innovations. All these, it is believed, were but signs of the breaking down of his physical health. He was far from well when he attended the banquet given in his honor in New York, and, gratifying as this tribute was to him, he seemed too weak to rally from the physical and the emotional strain.

How he himself would have appreciated in another's life the almost dramatic end that came to him. At the zenith of his career, his life well spent, his work well done, he rounded out his twenty-five years of service in the institution which had grown so dear to him. Happy in the appreciation and the affection of his loving friends, manifested in the presentation of those two loving cups (one from his board of managers, and one from his medical friends), typical as they are of

the genuine affection he always commanded, his death came as a climax to his splendidly successful career.

Dr. Talcott came to the institution for only half a day after his return from the banquet in New York. "Look after things—I'm going home to rest," he said, as he usually did on leaving the hospital in the afternoon, and none of us thought of the deeper significance in his words at this time. His illness of a few weeks is too painful to dwell upon; likewise his death, which occurred June 15th, 1902. One prefers rather to think of him as having entered into that rest which he so fondly craved.

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## CLARENCE W. CORNELL, M. D.

By A. WORRALL PALMER, M. D.

Clarence W. Cornell, M. D., was born May 1st, 1856, in New York City, where he spent a busy life and died on his forty-fifth birthday May 1, 1901.

His father, Edwin Cornell, who is still living at the advanced age of 85 years, was a cousin of the founder of the Cornell University. In 1890 the doctor married Mrs. Annie E. Rudd, who, with his mother, one sister and one brother, survived him.

He attended the public school and the college of the City of New York, from which he graduated in 1874. In 1877 he received his degree of M. D. from the New York Homœopathic Medical College. His medical career was commenced in the office of our late lamented William Tod Helmuth, M. D., from association with whom he seemed to develop an inherent aptitude for surgery. A few years later he became clinical assistant to the chair of surgery, and in 1890 was made lecturer in minor surgery in his medical Alma Mater. In the same year he was appointed on the staff of the Ward's Island Hospital, which position he held until his death. About this time he became one of the visiting surgeons to the Hahnemann Hospital.

He was a member of this State Society, The Society for Medico-Scientific Investigation and the Medico-Social Club.

While a good clinician and instructor, still he was at his best in the practical performance of his professional duties in the sick-room, where his personal magnetism and inspiration was felt and appreciated by all coming under his care.



## BIOGRAPHICAL SKETCH OF PRESIDENT JOHN L. MOFFAT.

Dr. John Little Moffat was born in Brooklyn, N. Y., June 14, 1853, the eldest child of Elizabeth Virginia Barclay and Dr. Reuben Curtis Moffat.

His grandfather, the first to make ever-pointed pencils in New York, went to California in '49, and became government assayer with such a reputation for probity that "as good as Moffat's gold" became a proverbial saying.

The subject of this sketch received his preliminary education in private and public schools and was graduated B. S. by Cornell University in 1873. After studying medicine a year, under Dr. W. S. Searle, he was one of the earliest to elect the three instead of the two years course in the New York Homœopathic Medical College, from which he was graduated M. D. in 1877 at the head of his class.

With the interlude of a trip westward around the world in 1885-6, he has practiced uninterruptedly in the city of his birth, studying electricity with the late Dr. John Butler, histology with Heitzmann, Sr., and making a specialty of the eye and ear since receiving in 1881 the degree Oculi et Auris Chirurgus from the New York Ophthalmic Hospital College.

Born in the New Church (Swedenborgian) he succeeded in 1894, upon his father's death, to the latter's long incumbency of the secretaryship to the Brooklyn Society and clerkship to its board of trustees —offices which he still holds.

In 1893 he married Elizabeth, daughter of Mrs. M. A. E. and the late George Murray Rhodes, of Antigua, W. I.; they have three children.

An ex-member of the Hamilton, Union League, Crescent and Alcyone Clubs, and always taking an active part in medical societies, it has ever been Dr. Moffat's pride that he has never sought nor worked for an office of any kind; each opportunity to so serve his fellow-members has sought him.

He lectured to the National Academy of Design on Anatomy in 1878, in the New York State Training School for Nurses from 1878 to 1883, and in the Brooklyn Homœopathic Hospital Training School for Nurses (of whose board of control he was a member) from 1894 to 1899.

For eighteen years (1877 to 1895) he held one clinic or another in the Brooklyn Homœopathic Hospital Dispensary, of which staff he was secretary 1882-5, president in 1890 and 1891, and consulting oculist and aurist from 1895 until it was closed in 1899.

Familiar from boyhood with the Brooklyn Homœopathic Hospital he was adjunct oculist in 1889 and 1890, chief of staff in 1894, and from the latter year until 1899, when the hospital was closed and sold to the city, was visiting physician and oculist. Since the hospital was

reopened, in 1901, as the Cumberland street branch of the County Hospital he has been one of its oculists and aurists.

Directly after graduating, President Moffat joined the Kings County Homœopathic Medical Society, of which he was secretary in 1882, 1883, 1884 and 1885; president in 1886, 1887 and 1888, and necrologist since 1900. Elected a delegate to the New York State Homœopathic Medical Society in 1881, two years later he became a permanent member, was elected secretary in 1884, 1885, 1889, 1890, 1891, 1892, 1893, 1894, 1895, 1896, 1897, 1898 and 1899; a vice-president in 1888 and president in 1902. He has not missed a meeting in the twenty-two years except the two that were held during his absence from the country.

Since 1881 he has been a member of the American Institute of Homœopathy, serving since 1899 on the standing committee which published in 1901 the Homœopathic Pharmacopeia of the United States, second edition.

An examiner in lunacy since 1881, he served as visiting physician to the Brooklyn Maternity from 1878 to 1883, to the Brooklyn Sea Side Home for Children in 1878 and 1879, and to the Home for Consumptives in 1882; has been consulting oculist to the Bethesda Sanitarium for Epileptics since its organization; is an associate member of the New York County Homœopathic Medical Society, a member of the New York Homœopathic Materia Medica Society, as well as of the New York Pædological Society, Homœopathic, and of the Medical Benefit Association, and since 1897 of the American Homœopathic Ophthalmological, Otological and Laryngological Society. In the test proving, conducted by the last mentioned, he is one of the directors of proving.

Under his presidency in 1901 the Alumni Association of the New York Homœopathic Medical College and Hospital, mainly through the initiative and efforts of Dr. J. B. Gregg Custis, took a more active and effective interest in the affairs of the college than ever before.

For the past two of his eight years' membership in the Hospital Saturday and Sunday Association of Brooklyn he has served as chairman of the committee on applications.

Always fond of literary work, Dr. Moffat has been one of the associate editors of the *North American Journal of Homœopathy* since 1889, and since 1901 editor-in-chief of the *Journal of Ophthalmology, Otology and Laryngology*, which he changed from a quarterly to a bi-monthly magazine.

For painstaking, thoroughness and faithfulness, President Moffat's career has but few equals. No other member of the State Society has such a record of regular attendance as has he. His thirteen years as secretary were an exhibition of his intellectual ability, foresight and unselfish devotion to the best interests of the State Society. In fact, this Society is and ever will be under a debt of gratitude to that most faithful secretary, now the honored President, Dr. John Little Moffat.



# CONSTITUTION AND BY-LAWS.

## CONSTITUTION.

### ARTICLE I.—NAME.

§ 1. In pursuance of Chap. 268, Laws of 1862, by which it was incorporated, this association shall be known as the Homœopathic Medical Society of the State of New York.

§ 2. Its objects shall be the advancement of homœopathic therapeutics and of all other departments of medicine and surgery.

### ARTICLE II.—MEMBERS.*

The Society shall be composed of permanent members, of delegates from homœopathic county societies and corporate institutions or associations of this State, and of such other members as may be chosen in conformity with the By-Laws.

### ARTICLE III.—OFFICERS.

§ 1. The officers of this Society shall be a president, three vice-presidents, a secretary, treasurer, necrologist and twelve censors (three of whom shall be selected from each of the four Censorial Districts of the State), who shall be elected by ballot by a majority of the active members present at each annual meeting.

§ 2. Their term of office shall commence at the close of the meeting at which they are elected, and shall continue for one year, until the adjournment of the next annual meeting, and until their successors are elected.

### ARTICLE IV.—SEAL.

The subjoined, either printed or embossed, shall be the official seal of the Society.


*This Society "may elect such a number of permanent, delegate or other members as may be provided for by the constitution or by-laws," and is "empowered to regulate and control its own membership". Laws of 1882, Chap. 209.

### ARTICLE V.—MEETINGS.*

§ 1. The annual meeting shall be held each year at Albany, commencing on the second Tuesday in February.

§ 2. A semi-annual meeting may be held at such time and place as the Society shall determine.

§ 3. Special meetings may be called by the Executive Board, or by the President, upon the call of ten active members.

### ARTICLE VI.—QUORUM.

Ten active members shall constitute a quorum.

### ARTICLE VII.—AMENDMENTS.

Any article of this constitution may be amended at an annual meeting by a two-thirds vote of the active members present, provided that a written notice shall have been given at the preceding annual meeting.

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## BY-LAWS.

### ARTICLE I.—DUTIES AND ELECTION OF OFFICERS.

§ 1. The duties and responsibilities of the president, vice-presidents, secretary, treasurer and necrologist shall be such as are usually incident to these offices.

§ 2. The President shall deliver an address at the annual or semi-annual meeting, appoint standing committees, bureaus and delegates, make appointments to fill vacancies and be ex-officio member of all committees.

§ 3. The Secretary, in addition to his other duties, shall annually edit the Transactions of the Society and the State Directory of Homœopathic Physicians, consulting with the Executive Board when he or they deem it necessary. He shall divide the delegate members into four classes as nearly equal as possible, one of which classes shall go out of office each year.

He shall be paid a salary of two hundred and fifty dollars per annum.

§ 4. The Treasurer shall keep the funds of the Society in a bank or trust company approved by the Executive Board, and the account shall stand in the name of the Society.

Each year he shall furnish a copy of the current issue of the Transactions to each permanent and senior member in good standing, and shall send to each county society not in arrears as many copies as it is entitled to delegates.

At each regular meeting he shall announce the names of such applicants as shall have failed to qualify for membership.

At each annual meeting he shall report the names of such members, institutions and county societies as are dropped for non-payment of dues, and shall furnish the tellers with a list of the active members entitled to vote.

He shall turn over to his successor all property of the Society in his charge.

In lieu of salary he shall be reimbursed for his traveling expenses incurred in attending the meetings of the Society.

§ 5. It shall be the duty of the Censors to consider all applications for permanent membership, reporting to the Society at the same or next meeting such as they judge to be properly qualified for election.

Three shall constitute a quorum.

§ 6. Any ten members may certify to the Secretary on or before December 15th of any year nominees for any or all elective offices to be filled at the next annual meeting.

On or before January 1st in each year the Secretary shall send to each member a list of nominees so certified to him and a ballot providing for nominations for the officers to be elected at the next annual meeting.

*This Society may select the time and place for holding its annual and other Meetings. Laws of 1875, chap. 449.



On or before January 25th, the Secretary shall send to each member a ballot made up of the two nominees for each office, providing such nominees shall have signified to him their acceptance of such nomination, who have received the highest number of votes previous to January 15th. Each member shall indicate his choice by a cross prefixed to one nominee for each office. The ballot shall be unsigned and sealed in an envelope marked "ballot" furnished by the Secretary, which shall be enclosed in an envelope endorsed by the member's name and address. A ballot shall be counted only in so far as it is marked in accordance with the above.

The polls shall close on February 5th. The ballots of members certified by the Treasurer as being in good standing shall be opened and counted, only in the presence of three tellers on or before the first day of the annual meeting. After canvassing the ballots the tellers shall certify the result to the President on or before 10 A. M. on the second day of the annual meeting.

In case the nominees for any office fail to receive a majority in the ballots cast previous to the annual meeting, open nominees for such office or offices shall be made at 11 A. M. on the second day of the annual meeting and balloting continued until a nominee receives a majority vote.

Three tellers shall be appointed by the President before February 1st of each year.

### ARTICLE II.—MEMBERSHIP.

§ 1. By the term "active members" is meant such permanent, delegate and senior members as are in good standing.

§ 2. Any physician desiring Permanent Membership must be of good moral and professional standing, and legally licensed to practice medicine under the laws of this State.

The candidate must sign the following form, properly filled out and indorsed: "I request membership in the Homœopathic Medical Society of the State of New York. I agree, if elected, to pay my dues promptly and regularly to the Society. I promise to return promptly to the Secretary my certificate of membership if and when I resign or am dropped from the Society. I hereby acknowledge that I believe *Similia Similibus Curantur*. I reside at No. ..... in ..... County of..... and am a graduate of.....in the year.....My license to practice is.....dated..... (Signed) (date). The undersigned permanent members indorse the above applicant as worthy of permanent membership in this Society. (Signed).....and.....".

After having been favorably reported on by the Censors and accepted by a majority vote of the active members present at a regular meeting, the candidate, upon the payment of five dollars, shall become a permanent member entitled to the rights and privileges of membership, including a certificate of membership.

If the first year's dues be not paid before the regular meeting next succeeding his or her election, such election shall be void and his or her name shall be published each year in a special list in the back of the Transactions.

The first, second, third and fourth paragraphs of this section shall be printed upon the application blanks.

§ 3. Each homœopathic county society in this State is entitled to elect, for a term of four years, as many Delegate Members of this Society as there are assembly districts in that county.

Permanent members shall not be eligible, and every delegate becoming a permanent member shall thereby cease to be a delegate member.

Each incorporated homœopathic institution or association in this State shall be entitled, upon payment of the annual dues, to single delegate representation in this Society, the term of the delegate to be four years.

Delegate members in good standing have all the rights and privileges of permanent membership except the certificate, eligibility to senior membership and election to the presidency.

§ 4. Any permanent member may be elected a Senior Member at an annual meeting, provided that at the time of such election he or she is in good standing and shall have paid dues for twenty years.

Senior members shall be exempt from dues and assessments, and shall be entitled to all rights and privileges of membership.

§ 5. Any physician or surgeon not a resident of this State, who has manifested superior attainments in medicine or one of its collateral sciences, may be elected an Honorary Member at an annual meeting, provided that the nomination, accompanied by reasons for conferring the honor, shall have been made at a previous regular meeting. Not more than three honorary members shall be elected in any one year.

Honorary members may participate in the proceedings of this Society (except that they shall not vote nor be eligible to office) and are requested to contribute papers. They shall be entitled to receive the volumes of Transactions to which they contribute papers.

### ARTICLE III.—DUES.

§ 1. The annual dues shall be three dollars from each permanent member and from each institution or association which appoints a delegate; from each county society there shall be due three dollars per annum for each delegate to which that society is entitled.

§ 2. Each permanent member shall pay a membership fee of five dollars, which shall include the dues for the current year, at the time of his or her election.

§ 3. No member in arrears shall be entitled to the privileges of membership.

Members three years in arrears shall be dropped from the roll, and their names published each year in a special list as having been dropped for non-payment of dues.

### ARTICLE IV.—COMMITTEES AND BUREAUS.

§ 1. The Executive Board, consisting of the president, vice-presidents, secretary and treasurer, shall act as the executive committee of the Society, attending to matters not otherwise provided for, or that may be referred to it.

When necessary it may call a special meeting of the Society, specifying time, place and object.

It shall serve as an advisory committee of publication with discretionary power as to the appearance in the Transactions of any given report or paper.

§ 2. The President-elect shall annually appoint the chairman of the Committee on State Medical Examiners and a chairman, with at least two members, of the Committee on Legislation and of each of the following bureaus: Materia Medica, Clinical Medicine and Pathology, Surgery, Obstetrics, Gynæcology, Pædiatrics, Neurology, Ophthalmology and Otology, Laryngology and Rhinology, and Public Health.

### ARTICLE V.—PAPERS.

§ 1. All papers, communications and reports read before or presented to this Society become thereby its property, and must be at once deposited with the Secretary. They may afterward, by means of copies, be published in medical journals if due credit be given to this Society.

§ 2. No paper nor report shall be received for publication that has previously been either published or presented to another society, or that is in an unfinished condition.

§ 3. Only fifteen minutes shall be allowed for the reading of a paper, ten minutes each for its opening and closing discussion, and five minutes each for other remarks discussing it. This rule may be suspended only by the unanimous consent of those present.

### ARTICLE VI.—STATE MEDICAL EXAMINERS.*

§ 1. This Society shall at each annual meeting, by a majority vote, nominate to the Regents of the University for appointment as State Medical Examiners at least twice as many persons as there are appointments to be made.

*Laws of New York, 1890, Chap. 507.



§ 2. Each nominee must be a member of this Society in good standing, must have been graduated in course from a reputable medical college, and must have been practicing medicine or surgery under the laws of this State for at least five years immediately prior to the first of July following said nomination.

§ 3. The Secretary shall send to each permanent and delegate member of this Society, a week before the annual meeting, the nominations by the Committee on State Medical Examiners of at least three times as many nominees as there are appointments to be made.

Each active member present may, between twelve and twelve-thirty P. M. of the second day of the annual meeting, deposit with two special tellers appointed by the president, a ballot for at least twice as many nominees as there are appointments to be made. Such names as receive a majority of the votes cast shall be presented to the Regents.

In case a sufficient number of names (twice the number of appointments to be made) do not receive a majority vote, the quota shall be filled by a ballot upon names submitted in open nomination.

§ 4. If charges of unprofessional or dishonorable conduct or continued neglect of duty are made against any State Medical Examiner representing this Society, the Society, after considering the matter in Committee of the Whole, may, by a majority vote, at any regular or special meeting submit the evidence in the case to the Regents and may request the removal of said Examiner.

§ 5. The Committee on State Medical Examiners shall consist of five members, to be elected by ballot at the annual meeting. The chairman shall be appointed from among their number by the president-elect within three weeks. Their term of office shall commence at the close of the meeting at which they are elected and shall continue one year, to the close of the next annual meeting, and until their successors are elected.

### ARTICLE VII.—ORDER OF BUSINESS.

At the meetings of this Society the following shall be the Order of Business, unless otherwise prescribed by the Executive Board or changed by the Society.

Prayer.
Communication from the President.
Appointments:
- Committee on Attendance;
- Committee on President's Address;
- Auditing Committee;
- Tellers.

Minutes of the last meeting.
Report of the Board of Censors.
Elections:
- of Members—Permanent, Senior, Honorary;
- of Officers (at time specified);
- of Nominees as State Medical Examiners (at time specified);
- of Committee on State Medical Examiners.

Reports:
- of Officers;
- of Committees;
- of Bureaus.

Miscellaneous business.

### ARTICLE VIII.—GOVERNMENT.

This Society shall be governed by the Code of Ethics adopted by the American Institute of Homœopathy, and by parliamentary usage as set forth in Roberts' Rules of Order for Deliberative Assemblies.

### ARTICLE IX.—AMENDMENT.

These By-Laws may be amended by a two-thirds vote of the active members present at an annual meeting, provided that written notice shall have been given at a previous regular meeting.

## STANDING RESOLUTIONS.

### DELINQUENT MEMBERS.

*Whereas*, It has been proposed that members dropped for non-payment of dues, asking to be reinstated should have their back dues remitted, and

*Whereas*, It would seem that such action would be prejudicial to the best interests of the Society by encouraging delinquency; therefore

*Resolved*, That the power of re-instatement in such cases be vested in the Executive Board, with the understanding that such leniency shall be exercised only in exceptional cases where unfortunate circumstances seem to render it necessary.

Adopted, Feb. 9, 1892.

### ANNUAL REPORT OF STATE MEDICAL EXAMINERS.

At each annual meeting the chairman of our Board of State Medical Examiners shall make a report to us of the work done by the Board during the year.

Adopted, Feb 14, 1893.

### PAPERS BY TITLE.

*Resolved*, That when the writer of a paper is not in attendance upon the meeting at which it is presented, the said paper shall be read by title. The only exception to be made to this rule shall be when the work of the Society is ahead of the schedule in point of time.

Adopted, Feb 12, 1895

### POSTAL NOTICE.

Not more than three nor less than two weeks previous to every regular meeting the Secretary shall send to each member a (postal card) notice of its date and place.

Adopted, Feb. 8, 1898.

### ANNUAL REPORT OF TREASURER.

The Treasurer shall present to the Society, in his annual report, a detailed statement of the expenditures of the Society, not merely giving the bulk expenditures alone.

Adopted Feb. 12th, 1901.

### REINSTATEMENT OF MEMBERS.

*Resolved*, That any former member of this Society who has resigned therefrom in good standing with the Society, may be reinstated upon his request, by making out and presenting the usual application without paying the initiation fee, when such application has been approved by the Censors.

The foregoing is approved and recommended by the Executive Committee.

J. T. GREENLEAF,
DEWITT G. WILCOX,
C. T. HAINES,
W. B. GIFFORD,
EDWARD G. COX.

Adopted Sept 25th. 1901.



## HONORARY MEMBERS.

| | | Elected. |
|---|---|---|
| Allen, Henry C. | 5142 Washington Ave., Chicago, Ill., | 1886 |
| Bartlett, Clarence | Arch St., Philadelphia, Pa., | 1890 |
| Biggar, Hamilton F. | Cleveland, O., | 1887 |
| Blake, J. Gibbs | England, | 1882 |
| Breyfogle, W. L. | New Albany, Ind., | 1881 |
| Budlong, John C. | Providence, R. I., | 1881 |
| Clifton, Arthur C. | 9 Park Parade, Northampton, Eng., | 1888 |
| De Derkey, F. F. | 311 W. 3d St., Los Angeles, Cal., | 1881 |
| Drummond, John | Manchester, Eng., | 1870 |
| Dudgeon, R. E. | 53 Montague Sq., London, W., Eng., | 1867 |
| Duncan, T. C. | 100 State St., Chicago, Ill., | 1869 |
| Edie, John L. | Leavenworth, Kan., | 1870 |
| Emerson, N. W. | 685 Boylston St., Boston, Mass., | 1900 |
| Gallinger, J. H. | Concord, N. H., | 1881 |
| Gilchrist, James G. | 215 College St., Iowa City, Ia., | 1888 |
| Hayward, John W. | 61 Shrewsbury Road, Birkenhead, Cheshire, Eng., | 1882 |
| Heath, Edwin R. | Kansas City, Kan., | 1868 |
| Henderson, William | Edinburgh, Scotland, | 1869 |
| Hirschel, B. | Dresden, Saxony, Germany, | 1871 |
| James, Bushrod W. | Green & 18th Sts., Philadelphia, Pa., | 1868 |
| Jones, Samuel A. | Ann Arbor, Mich., | 1882 |
| Kinne, Theodore Y. | Paterson, N. J., | 1893 |
| Linnell, E. H. | 61 Broadway, Norwich, Conn., | 1891 |
| Madden, H. R. | London, Eng., | 1870 |
| Mandeville, F. B. | Newark, N. J., | 1873 |
| McGeorge, Wallace | 521 Broadway, Camden, N. J., | 1884 |
| Packard, Horace | 470 Commonwealth Ave., Boston, Mass., | 1900 |
| Peck, George B. | 865 N. Main St., Providence, R. I., | 1882 |
| Pope, Alfred C. | Grantham, Eng., | 1871 |
| Roth, Mathias | London, Eng., | 1871 |
| Runnels, O. S. | 203 N. Meridian St., Indianapolis, Ind., | 1882 |
| Sanders, John C. | 608 Prospect St., Cleveland, O., | 1865 |
| Shears, G. F. | 3130 Indiana Ave., Chicago, Ill., | 1900 |
| Skinner, Thomas | 6 York Pl., London, W., Eng., | 1878 |
| Sparhawk, George E. E. | Burlington, Vt., | 1875 |
| Van Lennep, W. B. | 1421 Spruce St., Philadelphia, Pa., | 1900 |
| Wesselhoeft, Conrad | 291 Boylston St., Boston, Mass., | 1888 |
| Wilson, David | London, Eng., | 1865 |
| Wood, James C. | 122 Euclid Ave., Cleveland, O., | 1891 |
| Worcester, Samuel | 597 Congress St., Portland, Me., | 1873 |

# OFFICERS, 1850—1902.

| ar. | Presidents. | 1st Vice-President. | 2nd Vice-President. | 3rd Vice-President. | Secretary. | Treasurer. | Cor. Secretary. |
|---|---|---|---|---|---|---|---|
| 50. | *Isaac M. Ward, Albany. | *D. Chase. | *R. S. Bryan. | *A. C. Ball. | *Henry D. Paine. | | |
| 51. | *F. Vanderbergh, New York. | *L. Clary. | *F. Humphreys. | *Geo. W. Lewis. | " | | |
| 52. | *Lyman Clary, Syracuse. | *Alonzo S. Ball | *E. L. Coburn. | *D. Chase. | " | | |
| 53. | *Alonzo S. Ball, New York. | *N. H. Warner | S. S. Guy. | *L. B. Wells. | " | | |
| 54. | *Amherst Childs, Waterloo. | *Henry Adams. | *Josiah Bowers. | *E. T. Richardson. | " | | |
| 55. | Samuel S. Guy, Brooklyn. | *M. M. Matthews. | *R. S. Bryan. | *David Springsteed. | " | | |
| 56. | *M. M. Matthews, Rochester. | *J. M. Quinn. | *Henry Adams. | *L. B. Wells. | " | | |
| 57. | *R. S. Bryan, Troy. | *A. P. Cook. | *L. B. Wells. | *J. C. Peters. | " | *J. W. Cox. | |
| 61. | *Ethan A. Potter, Oswego. | *Simeon A. Cook. | *A. R. Wright. | *Cornelius Ormes. | Horace M. Paine. | " | |
| 62. | *Jacob Beakley, New York. | *A. R. Wright. | *E. A. Munger. | W. S. Searle. | " | *L. B. Wells. | |
| 63. | *Henry D. Paine, New York. | *William Wright. | C. W. Boyce. | Asa S. Couch. | " | " | |
| 64. | *Erastus A. Munger, Waterville. | S. S. Guy. | A. R. Morgan. | Asa S. Couch. | " | " | |
| 65. | *Abijah P. Cook, Hudson. | *Benj. F. Cornell. | *Benj. F. Bowers. | *L. M. Kenyon. | " | " | H. B. Fellows. |
| 66. | *Horatio Robinson, Auburn. | *Lucien B. Wells. | *Wm. B. Stebbins. | *Edgar B. Cole. | " | *J. S. Delavan. | " |
| 67. | *B. F. Cornell, Moreau Station. | *S. B. Barlow. | William H. Watson. | L. M. Pratt. | H. B. Fellows. | *J. W. Cox. | *E. D. Jones. |
| 68. | William H. Watson, Utica. | T. F. Allen. | *T. L. Brown. | *D. F. Bishop. | H. M. Paine. | W. S. Searle. | " |
| 69. | *William Wright, Brooklyn. | E. B. Holmes. | *Henry Minton. | *E. P. K. Smith. | " | " | " |
| 70. | *Lucien B. Wells, Utica. | *Edwin H. Hurd. | *Ezra P. K. Smith. | T. Franklin Smith. | " | " | " |
| 71. | *John F. Gray, New York. | T. Franklin Smith. | J. C. Raymond. | *A. W. Holden. | " | *J. F. McKown. | " |
| 72. | *H. A. Houghton, Keesville. | *Charles Sumner. | H. S. Hutchinson. | G. L. Gifford. | " | Nelson Hunting. | L. M. Pratt. |
| 73. | *E. Darwin Jones, Albany. | *D. F. Bishop. | *J. Ralsey White. | R. E. Miller. | *Frank L. Vincent. | " | " |
| 74. | *L. M. Kenyon, Buffalo. | *A. E. Sumner. | *S. C. Knickerbocker. | *Henry Sales. | " | *F. L. Vincent. | " |
| 75. | *A. W. Holden, Glens Falls. | E. M. Kellogg. | *H. V. Miller. | R. S. Bishop. | " | *E. D. Jones. | " |
| 76. | T. F. Allen, New York. | *A. R. Wright. | William Gulick. | Henry R. Stiles. | Alfred K. Hills. | *F. L. Vincent. | " |
| 77. | Egbert Guernsey, New York. | William Gulick. | Henry R. Stiles. | H. D. Brown. | " | E. S. Coburn. | H. L. Waldo. |
| 78. | William Gulick, Watkins. | *A. R. Wright. | W. M. L. Fiske. | A. P. Throop. | " | " | " |
| 79. | Asa S. Couch, Fredonia. | Alfred K. Hills. | E. Hasbrouck. | J. J. Mitchell. | H. L. Waldo. | " | *A. P. Hollett. |
| 80. | *A. R. Wright, Buffalo. | E. Hasbrouck. | *N. Osborne. | R. A. Adams. | " | " | " |
| 81. | *Selden H. Talcott, Middletown. | J. J. Mitchell. | A. J. Frantz. | *G. W. Peer. | *A. P. Hollett. | " | *C. E. Jones. |
| 82. | J. J. Mitchell, Newburgh. | E. Hasbrouck. | W. B. Kenyon. | W. M. Butler. | " | " | NECROLOGIST. |
| 83. | Everitt Hasbrouck, Brooklyn. | W. B. Kenyon. | A. P. Williamson. | L. A. Clark. | " | " | *A. W. Holden. |
| 84. | Edward S. Coburn, Troy. | *Henry C. Houghton. | *H. M. Dayfoot. | *A. P. Hollett. | John L. Moffat. | H. L. Waldo. | " |
| 85. | Marshall O. Terry, Utica. | *A. P. Hollett. | N. B. Covert. | George M. Dillow. | " | E. S. Coburn. | " |
| 86. | *Henry C. Houghton, New York. | F. Park Lewis. | *T. L. Brown. | E. W. Bryan. | *H. M. Dayfoot. | " | " |
| 87. | Horace M. Paine, Albany. | *Wm. Tod Helmuth. | J. M. Lee. | Geo. E. Gorham. | " | " | " |
| 88. | *Wm. Tod Helmuth, New York. | Thos. D. Spencer. | *L. A. Bull. | John L. Moffat. | " | Arthur B. Norton. | " |
| 89. | *Herbert M. Dayfoot, Rochester. | F. F. Laird. | J. T. Greenleaf. | Sidney F. Wilcox. | John L. Moffat. | " | H. L. Waldo. |
| 90. | George M. Dillow, New York. | N. B. Covert. | J. M. Lee. | W. B. Gifford. | " | " | " |
| 91. | F. Park Lewis, Buffalo. | A. B. Norton. | L. L. Brainard. | J. W. Sheldon. | " | Charles Deady. | H. D. Schenck. |
| 92. | Wm. M. L. Fiske, Brooklyn. | *L. A. Bull. | E. J. Bissell. | J. W. Candee. | " | " | " |
| 93. | J. M. Lee, Rochester. | J. W. Candee. | W. J. Garnsey. | Mary A. Brinkman. | " | " | E. Hasbrouck. |
| 94. | James Montfort Schley, New York. | E. J. Bissell. | W. B. Gifford. | W. B. Winchell. | " | " | " |
| 95. | *Charles E. Jones, Albany. | W. B. Gifford. | D. J. Roberts. | W. L. Hartman. | " | " | " |
| 96. | Edwin H. Wolcott, Rochester. | G. G. Shelton. | I. Townsend. | *A. R. Wright. | " | " | W. S. Garnsey. |

# OFFICERS—CONTINUED

| . | Presidents. | 1st Vice-President. | 2nd Vice-President. | 3rd Vice-President. | Secretary. | Treasurer. | Cor. Secretary. |
|---|---|---|---|---|---|---|---|
| 97. | Eugene H. Porter, New York. | John W. LeSeur. | J. W. Dowling. | E. G. Cox. | John L. Moffat. | Charles Deady. | W. S. Garnsey. |
| 98. | A. B. Norton, New York. | D. G. Wilcox. | F. W. Adriance. | H. D. Schenck. | " | " | " |
| 99. | J. W. Sheldon, Syracuse. | F. W. Adriance. | G. E. Gorham. | N. M. Collins. | " | " | " |
| 00. | William Morris Butler, Brooklyn. | E. W. Bryan. | L. A. Martin. | Emily F. Swett. | DeWitt G. Wilcox. | " | " |
| 01. | John T. Greenleaf, Owego. | C. T. Haines. | E. G. Cox. | W. H. Bishop. | " | W. B. Gifford. | " |
| 02. | John L. Moffat, Brooklyn. | M. C. Ashley. | Bukk G. Carleton. | C. A. Gwynn. | " | Frederick J. Cox. | " |

*Deceased.

## MEMBERS DROPPED FOR NON-PAYMENT OF DUES.

*(By-Law III., §3, ¶2.)*

Anderson, H. A. ..... 1898
Bachman, Geo. A. ..... 1901
Banker, P. A. ..... 1898
Bass, E. C. ..... 1884
Beach, G. H. ..... 1884
Birdsall, W. G. ..... 1901
Bigelow, J. G. ..... 1884
Bleecker, W. H. ..... 1901
Blighton, W. V-R. ..... 1898
Blodgett, T. L. ..... 1884
Bloss, R. D. ..... 1884
Bolan, L. W. ..... 1901
Boocock, Robert ..... 1900
Boyce, C. W. ..... 1885
Bradner, Ira S. ..... 1889
Brown, H. D. ..... 1884
Bull, A. T. ..... 1884
Burdick, A. H. ..... 1900
Campbell, C. E. ..... 1891
Campbell, M. W. ..... 1884
Carpenter, L. W. ..... 1898
Carr, A. B. ..... 1892
Chamberlain, J. H. ..... 1894
Clark, A. J. ..... 1889
Clark, F. W. ..... 1900
Coffin, W. H. ..... 1888
Cole, D. D. ..... 1900
Cowl, W. Y. ..... 1894
Crandall, E. L. ..... 1900
Curtiss, A. M. ..... 1895
Dake, Addie B. ..... 1894
Diehl, W. ..... 1898
Dods, A. Wilson ..... 1888
Doolittle, J. F. ..... 1889
Finch, Joseph ..... 1887
Fisher, E. A. ..... 1895
Fiske, Katrina C. ..... 1898
Flint, E. H. ..... 1895
Fulford, G. H. ..... 1888
Fuller, H. E. ..... 1890
Gallup, M. W. ..... 1889
Gamman, A. M. ..... 1893
Gifford, B. R. ..... 1890
Gifford, G. A. ..... 1884
Goodrich, S. W. ..... 1900
Grant, B. F. ..... 1888
Greeley, G. H. ..... 1884
Groves, C. A. ..... 1893
Gwynn, W. M. ..... 1884
Hadley, W. A. M. ..... 1898
Hadley, C. H. ..... 1900
Halbert, John S. ..... 1896
Hale, C. D. ..... 1888
Hand, George F. ..... 1895
Hanford, Harold W. ..... 1896
Hanford, S. C. ..... 1884
Hanford, W. H. ..... 1884
Hanor, Azro Chase ..... 1896
Hathaway, W. E. ..... 1893
Hawley, W. A. ..... 1884
Hibbard, G. C. ..... 1884
Houghton, B. L. ..... 1893
King, G. H. ..... 1888
Linendall, R. A. ..... 1889
Lindsey, J. S. ..... 1887
Long, William E. ..... 1892
Loomis, E. ..... 1883
Lowery, C. ..... 1884
McCrea, P. A. ..... 1900
MacIvor, Abbie H. ..... 1898
Marsh, James M. ..... 1896
McKenzie, J. E. ..... 1898
McKinney, Susan S. ..... 1898
McMasters, Mrs. M. ..... 1900
McPherson, J. C. ..... 1892
Miller, Isaac ..... 1886
Millspaugh, C. F. ..... 1890
Moore, J. de V. ..... 1892
Morgan, E. J., Jr. ..... 1887
Mosher, Charles M. ..... 1892
Otis, Clark ..... 1892
Palmer, G. B. ..... 1890
Pearsall, S. J. ..... 1898
Peckham, J. J. ..... 1888
Peterson, O. W. ..... 1889
Pritchard, G. C. ..... 1898
Proctor, J. C. ..... 1893
Rabe, F. E. ..... 1901
Radway, C. W. ..... 1900
Raymond, J. C. ..... 1883
Reynolds, P. L. F. ..... 1884
Rice, A. B. ..... 1886
Robinson, E. H. ..... 1898
Robinson, R. W. ..... 1895
Rodenberger, E. M. ..... 1898
Seegar, F. ..... 1893
Seeley, W. W. ..... 1893
Smith, Sidney E. ..... 1898
Stebbins, J. H. ..... 1893
Stobbs, A. V. ..... 1888
Sweeting, M. F. ..... 1884
Sweeting, S. C. ..... 1898
Swift, Charles L. ..... 1884
Thorn, Sarah E. ..... 1892
Tracy, G. A. ..... 1888
True, R. S. ..... 1892
Truman, I. P. ..... 1889
Voak, J. B. ..... 1891
Walker, C. E. ..... 1900
Wallace, A. E. ..... 1884
Walters, C. A. ..... 1898
Ward, H. J. ..... 1884
Warren, S. C. ..... 1884
Welch, C. D. ..... 1891
Wellman, W. I. ..... 1883
West, James A. ..... 1892



White, J. N. ..... 1884
White, W. Hanford ..... 1888
Whiton, Alpha M. ..... 1895
Winterburn, G. W. ..... 1898
Woodbury, W. L. ..... 1886
Wright, F. M. ..... 1890
Young, C. H. ..... 1898
Zoller, W. ..... 1888

## MEMBERS-ELECT WHO FAILED TO QUALIFY.

Archer, D. E. ..... 1894
Ayres, E. F. M. ..... 1899
Barnum, F. L. ..... 1894
Bennett, D. G. ..... 1894
Campbell, E. E. ..... 1893
Chaplain, F. T. ..... 1881
Conklin, Fannie Donovan ..... 1899
Dyer, Charles L. ..... 1895
Evans, C. V. S. ..... 1894
Fairbank, Stuart J. ..... 1899
Gayde, E. Appleton ..... 1900
Gifford, Alden ..... 1862
Hodge, John W. ..... 1899
Kaiser, R. C. ..... 1894
Knight, S. H. ..... 1893
McKenzie, J. A. ..... 1895
Read, J. S. ..... 1891
Reed, J. A. ..... 1894
Wilcox, F. P. ..... 1893
Zimmermann, Charles ..... 1892

## PERMANENT MEMBERS.

*(Senior Members in Small Capitals.)*

Adams, George F. ..... Gowanda State Homœopathic Hospital, Gowanda, 1898
Adams, Myron H. ..... 821 Granite Building, Rochester, 1892
Adams, R. A. ..... 46 N. Fitzhugh, Rochester, 1899
Adriance, F. W. ..... 306 Lake, Elmira, 1883
Albertson, C. S. ..... 9 W. Bridge, Oswego, 1900
Allan, Arthur G. ..... 14 W. 32d, New York, Mhn., 1895
Allen, Emma T. P. ..... 310 Clermont Ave., New York, Bkn., 1899
Allen, Herbert C. ..... 304 Clermont Ave., New York, Bkn., 1899
Allen, Paul ..... 3 E. 48th, New York, Mhn., 1892
Allen, T. F. ..... 3 E. 48th, New York, Mhn., 1879
Alliaume, Chas. E. ..... 8 Tracey, Utica, 1902
Ambler, J. Edgar ..... 134 East 19th, New York, Mhn., 1893
Andrews, B. P. ..... 103 Main, Dansville, 1893
Angel, Milton H. ..... Salt Point, 1902
Arthur, Daniel H. ..... Gowanda State Homœopathic Hospital, Gowanda, 1891
Ashley, M. C. ..... Middletown, 1894
Austin, Edson C. ..... Elkhorn, Wis., 1896
Austin, A. Eugene ..... 17 East 66th, New York, Mhn., 1902
Avery, E. W. ..... 16 Hancock, New York, Bkn., 1889
Babbitt, Otis H. ..... 178 Genesee, Auburn, 1892
Baker, Jennie v. H. ..... 512 Bedford Ave., New York, Bkn., 1889
Baldwin, G. E. ..... 500 University Ave., Syracuse, 1898
Baldwin, Jared G. ..... 8 E. 41st, New York, Mhn., 1894
Ball, Halsey J. ..... Scott, 1891
Barker, C. E. ..... Spafford, 1902
Barnard, J. S. ..... 2112 N. Charles, Baltimore, Md., 1886
Barnes, Charles F. ..... Weedsport, 1893
Barnes, Frank H. ..... Stamford, Ct., 1896
Barrus, Clara ..... Middletown, 1894
Baylies, B. L'B. ..... 418 Putnam Ave., New York, Bkn., 1883

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| Beals, Herbert | 188 Franklin, Buffalo, | 1899 |
| Bell, Willard N | 6 Greene, Ogdensburgh, | 1890 |
| Bennet, G. H. R | 21 S. Portland Av., New York, Bkn., | 1889 |
| Benson, R. F., Jr | 2 St. Paul Pl., Troy, | 1886 |
| Berghaus, Alex | 138 E. 65th, New York, Mhn., | 1888 |
| Besemer, Martin | 40 S. Albany, Ithaca, | 1897 |
| Best, F. W | 66 Ball, Port Jervis, | 1893 |
| Beyea, J. L | 217 Second Ave., New York, Mhn., | 1894 |
| Bierbauer, Bruno W | 47 Pierrepont, New York, Bkn., | 1898 |
| Birch, Chas. E | White Plains, | 1894 |
| Birdsall, Edgar | 1038 Bedford Ave., New York, Bkn., | 1902 |
| Birdsall, S. T | 80 Ridge, Glens Falls, | 1883 |
| Birdsall, T. P | Patterson, | 1892 |
| Bishop, F. M | Newark Valley, | 1891 |
| Bishop, W. H | 56 W. 48th, New York, Mhn., | 1893 |
| Bissell, E. J | 75 S. Fitzhugh, Rochester, | 1889 |
| Blackley, C. A | 247 Washburn, Lockport, | 1901 |
| Blackman, W. W | 519 Clinton Ave., New York, Bkn., | 1890 |
| Bond, Mary E | 122 Lexington, New York, Mhn., | 1892 |
| Borden, G. T | Caledonia, | 1887 |
| Boyle, Chas. C | 49 W. 37th, New York, Mhn., | 1888 |
| Boynton, F. H | 36 W. 50th, New York, Mhn., | 1888 |
| Brainard, L. L | 2 Cronkhite Block, Little Falls, | 1883 |
| Brewster, Geo. F | Middletown, | 1902 |
| Brinkman, Mary A | Brewster, | 1891 |
| Brown, E. V | N. Tarrytown, | 1886 |
| Brown, M. Belle | 50 W. 51st, New York, Mhn., | 1892 |
| BRYAN, E. W. (1900) | 22 W. Erie Ave., Corning, | 1880 |
| Bryant, Wm. C | 66 Greene Ave., New York, Bkn., | 1899 |
| Buchanan, T. Drysdale | 328 W. 24th, New York, Mhn., | 1902 |
| Buchholz, Louise Z | 73 E. 8th, New York, Mhn., | 1892 |
| Buell, E. S. (Lic.) | South Greece, | 1893 |
| Buell, Jesse W | 61 Clinton Ave., S., Rochester, | 1889 |
| BULLARD, D. H. (1887) | Glens Falls, | 1864 |
| Bulmer, Geo. W | 1210 Bushwick Av., New York, Bkn., | 1891 |
| Burnham, Clark | 182 Clinton, New York, Bkn., | 1889 |
| Butler, Wm. M | 507 Clinton Ave., New York, bkn., | 1881 |
| Calisch, Alex. C | 55 W. Bridge, Oswego, | 1896 |
| Candee, J. W | 501 Fayette Park, Syracuse, | 1885 |
| Capron, C. G | 219 Genesee, Utica, | 1900 |
| Carleton, Bukk G | 75 W. 50th, New York., Mhn., | 1892 |
| Carpenter, A. D | 1118 Genesee, Buffalo, | 1902 |
| CARROLL, S. H. (1900) | 234 State, Albany, | 1874 |
| Cassidy, Georgia A | 703 Nostrand Ave., New York, Mhn., | 1891 |
| Chadwick, John G | 382 Franklin, Buffalo, | 1899 |
| Chamberlin, W. T | 305 Sixth Ave., New York, Bkn., | 1899 |
| Chandler, D. Henry | Cornwall-on-Hudson, | 1894 |
| Chapin, Edward | 21 Schermerhorn, New York, Bkn., | 1883 |
| Charles, Emily C | 51 W. 127th, New York, Mhn., | 1898 |
| Chase, C. E | 230 Genesee, Utica, | 1882 |
| Chase, J. Oscoe | 214 E. 53d, New York, Mhn., | 1888 |
| Church, H. A | 601 Warren, Syracuse, | 1898 |
| Clark, Byron G | 25 N. 74th, New York, Mhn., | 1891 |
| Clark, L. A | Cambridge, | 1879 |
| Clapp, Charles R | 427 Hayward Ave., Rochester, | 1901 |
| Coburn, Edward S | 04 Fourth, Troy, | 1874 |
| Cochrane, H. D | 59 Eagle, Albany, | 1900 |
| Collins, N. M | 43 East Ave., Rochester, | 1886 |
| Conklin, R. C | 29 Ellicott Ave., Batavia, | 1902 |
| Cook, C. P | Hudson, | 1872 |
| Cook, J. T | 636 Delaware Ave., Buffalo, | 1883 |
| Cooper, C. S | Skaneateles, | 1896 |



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|---|---|---|
| Corwin, Elizabeth | 104 Main, Binghamton, | 1892 |
| COUCH, ASA S. (1894) | Fredonia, | 1864 |
| Covert, N. B | Geneva, | 1878 |
| Covert, Rynear B | Seneca Falls, | 1892 |
| Cox, Edward G | 261 State, Albany, | 1894 |
| Cox, F. J | 109 State, Albany, | 1894 |
| Cox, G. A | 80 S. Swan, Albany, | 1878 |
| Critchlow, Geo. Reed | 505 Norwood, Buffalo, | 1901 |
| Crum, Harry Herbert | 212 Hazen, Ithaca, | 1901 |
| Crump, Walter Gray | 693 Madison Ave., New York, Mhn., | 1902 |
| Danforth, L. L | 49 W. 52d, New York, Mhn., | 1888 |
| Davies, Thomas F | 359 W. 116th, New York, Mhn., | 1901 |
| Davis, J. E. L | 743 Madison Ave., New York, Mhn., | 1891 |
| Deady, Charles | 151 W. 73rd, New York, Mhn., | 1888 |
| Deady, H. P | Liberty, | 1899 |
| Dean, L. W | 41 Gardner Building, Utica, | 1899 |
| Dearborn, H. M | 146 W. 57th, New York, Mhn., | 1888 |
| De Camp, Frank H | 332 E. Water, Elmira, | 1901 |
| Decker, W. M | 242 Ashland, Buffalo, | 1883 |
| De La Barre, W. C | 224 Central Pk., New York, Mhn., | 1894 |
| Demarest, J. H | 1969 Madison Av., New York, Mhn., | 1892 |
| Denison, R. N | 55 Eighth Ave., New York, Bkn., | 1899 |
| Denslow, M. H | Marbledale, Conn., | 1894 |
| Deuel, W. Estus | Chittenango, | 1891 |
| Dewey, Willis A | Ann Arbor, Mich., | 1894 |
| Dickie, Perry | 17 Schermerhorn, New York, Bkn., | 1902 |
| Dieffenbach, Wm. H | 1748 Broadway, New York, Mhn., | 1902 |
| Dillingham, T. M | 8 W. 49th, New York, Mhn., | 1891 |
| Dillow, George M | 223 W. 57th, New York, Mhn., | 1889 |
| Doane, W. H | Pittsford, | 1893 |
| Doughty, Francis E | 512 Madison Ave., New York, Mhn., | 1877 |
| Dowling, J. Ivimey | 223 State, Albany, | 1900 |
| Dowe, F. LeC | S. Boulevard & Briggs Ave., New York, Mhn., | 1892 |
| Dowling, J. W | 116 W. 48th, New York, Mhn., | 1889 |
| Drury, Alfred | 251 Church, Paterson, N. J., | 1901 |
| Durrin, Wm. C | 1038 Bedford Ave., New York, Bkn., | 1902 |
| DuBois, W. C | 519 S. Salina, Syracuse, | 1893 |
| Dutcher, M. T | Owego, | 1884 |
| Eddy, Ermina C | 500 William, Elmira, | 1883 |
| Eife, A. F | 175 W. 10th, New York, Mhn., | 1888 |
| Eisenbrey, E. H | Gloversville, | 1897 |
| Elliott, Amos H | 480 Monroe, New York, Bkn., | 1890 |
| Erb, Peter | 32 Palace Arcade, Buffalo, | 1891 |
| Everett, Edward A | State Hospital, Middletown, | 1902 |
| Fancher, E | 16 Orchard, Middletown, | 1885 |
| Faust, Louis | 19 Jay, Schenectady, | 1885 |
| Faust, Wm. P | 29 Jay, Schenectady, | 1898 |
| Fay, R. P | 165 Warburton Ave., Yonkers, | 1892 |
| Ferrier, James | 166 E. 111th, New York, Mhn., | 1896 |
| FISKE, WM. M. L. (1900) | 1140 Dean, New York, Bkn., | 1875 |
| Fiske, E. Rodney | 1140 Dean, New York, Bkn., | 1896 |
| Follet, W. M | Seneca Falls, | 1891 |
| Foster, E. Agate | Patchogue, | 1891 |
| Foster, H. A | 3 St. John's Pl., Buffalo, | 1891 |
| Foster, W. E | 126 Madison Ave., Flushing, | 1892 |
| Fowler, W. P | 63 Clinton Ave., S., Rochester, | 1876 |
| Fralick, W. G | 778 Madison Ave., New York, Mhn., | 1892 |
| Francisco, D. E | Omaha, Neb., | 1897 |
| Franklin, E. D | 325 W. 14th, New York, Mhn., | 1888 |
| Frazer, F. M | 41 W. 45th, New York, Mhn., | 1894 |
| Frazier, L. A | 124 Division, Amsterdam, | 1892 |

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|---|---|---|
| Freeman, Wm. Hazen | 297 Logan, Brooklyn, | 1902 |
| Frye, M. M. | 167 Genesee, Auburn, | 1884 |
| Garnsey, W. S. | 93 N. Main, Gloversville, | 1888 |
| Garrison, J. B. | 111 E. 70th, New York, Mhn., | 1888 |
| Gennerich, Chas. | 181 East 64th, New York, Mhn., | 1902 |
| Getman, A. D. | 17 Ford Ave., Oneonta. | 1893 |
| Gifford, G. L. | Hamilton, | 1868 |
| Gifford, W. B. | Attica, | 1886 |
| Gillespie, Lizzie S. | 309 E. 14th, New York, Mhn., | 1889 |
| Gillette, Myra A. | Medina, | 1891 |
| Ginnever, Arthur | Glen St., Glen Cove, | 1902 |
| Given, J. B. | 463 Ninth, Brooklyn, | 1900 |
| Givens, A. J. | Stamford, Conn., | 1891 |
| Gore, Jennie E. | 1145 Park Ave., New York, Mhn., | 1892 |
| Gorham, G. E. | 218 State, Albany, | 1900 |
| Gorton, D. A. | Montague, New York, Bkn., | 1890 |
| Graham, M. E. | 10 Jones Ave., Rochester, | 1893 |
| Grant, A. R. | 366 Genesee, Utica, | 1901 |
| Green, Arba R. | 25 Second, Troy, | 1902 |
| Greene, C. R. F. | Peekskill, | 1894 |
| Greenleaf, J. T. | Owego, | 1884 |
| Gregory, G. W. | 370 W. Church, Elmira. | 1895 |
| Gridley, G. L. | 605 Warren, Syracuse, | 1895 |
| GUERNSEY, EGBERT (1899) | 180 W. 59th, New York, Mhn., | 1865 |
| GULICK, WILLIAM (1885) | Watkins, | 1865 |
| Guy, Clement N. | Greene, | 1901 |
| Gwynn, Charles A. | 13 Grover, Auburn, | 1899 |
| Gwynn, William M. | 14 Grover, Auburn, | 1901 |
| Haines, C. T. | 42-43 Gardner Bldg., Utica, | 1891 |
| Hall, M. J. | Mamaroneck, | 1893 |
| Hall, C. B. | Copenhagen, | 1902 |
| Hallett, G. De Wayne | 132 W. 81st, New York, Mhn., | 1902 |
| Hallock, J. H. | Saranac Lake, | 1880 |
| Hamlin, F. W. | 130 W. 48th, New York, Mhn., | 1892 |
| Hardy, W. J. | Belmont, | 1901 |
| Harris, J. W. | 229 East 124th, New York, Mhn., | 1902 |
| Hartley, W. G. | 345 W. 34th, New York, Mhn., | 1891 |
| Hartman, W. L. | 737-741 University Bldg., Syracuse, | 1893 |
| HASBROUCK, E. (1901) | 389 Fourth, New York, Bkn., | 1873 |
| Hasbrouck, Joseph | Dobb's Ferry, | 1899 |
| Hasbrouck, Sayer | 117 Broad, Providence, R. I., | 1883 |
| Hathaway, H. S. | 146 W. 92d, New York, Mhn., | 1892 |
| HAVILAND, N. H. (1901) | Fulton, | 1880 |
| Hawley, H. Reed | Staatsburgh, | 1897 |
| Hawley, L. B. | Clyde, | 1893 |
| Haywood, Chas. W. | Stamford, Conn., | 1898 |
| Haywood, George M. | 48 Clinton Ave., S., Rochester, | 1890 |
| Haywood, Mrs. Julia F. | 612 West Ave., Rochester, | 1890 |
| Helfrich, C. H. | 542 Fifth Ave., New York, Mhn., | 1888 |
| Helmuth, W. T. | 26 E. 62nd, New York, Mhn., | 1888 |
| Hibbard, D. M. | 112 Berry, Olean, | 1893 |
| Hill, Emily L. | 250 W 94th, New York, Mhn., | 1899 |
| Hinman, E. L. | 84 W. Oneida, Oswego, | 1898 |
| Hodge, W. H. | 8 Gluck Block, Niagara Falls, | 1895 |
| Honan, W. F. | 71st & Broadway, New York, Mhn., | 1894 |
| Hopkins, W. W. | Geneva, | 1894 |
| Horton, Claude A. | 45 Maple, Glens Falls. | 1902 |
| Horton, E. T. | Whitehall, | 1897 |
| Hough, W. D. | Niagara Falls, | 1891 |
| Howe, J. M. | 58 W. 47th, New York, Mhn., | 1894 |
| Howland, R. B. | 306 Lake, Elmira, | 1897 |
| Hoyt, E. F. | 39 W. 58th, New York, Mhn., | 1894 |



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| Hoyt, Gordon W. | 808 Madison, Syracuse, | 1898 |
| Hoyt, H. W. | 75 S. Fitzhugh, Rochester, | 1893 |
| Hunt, Dwight B. | 159 Madison Ave., New York, Mhn., | 1887 |
| HUNTING, NELSON (1897) | 155 Hamilton, Albany, | 1872 |
| Hurd, S. Wright | 78 Main, Lockport, | 1891 |
| Hutchins, H. S. | Batavia, | 1870 |
| Hutchinson, John | 78 E. 55th, New York, Mhn., | 1902 |
| Hyde, L. D. | Montclair, N. J., | 1894 |
| Iler, George Hills | 243 McDonough, New York, Bkn., | 1902 |
| Ives, Nathaniel Holmes | 145 Second Ave., Mt. Vernon, | 1902 |
| Jacobson, Frank A. | 269 Grand, Newburgh, | 1891 |
| Jeffery, George C. | 343 Jefferson Ave., New York, Bkn., | 1887 |
| Jenkins, George H. | 139 Main, Binghamton, | 1897 |
| Johnson, Howard P. | 15 Port Watson, Cortland, | 1902 |
| Johnston, C. L. | 467 Vanderbilt Ave., N. Y., Bkn., | 1890 |
| Kastendieck, J. T. W. | 120 Hooper, New York, Bkn., | 1890 |
| Keator, Bruce S. | Asbury Park, N. J., | 1894 |
| Keegan, Wm. A. | 44 Clinton Ave., S., Rochester, | 1890 |
| Keese, J. Mumford | 211 Schonnard, Syracuse, | 1899 |
| Keith, Horace G. | 107 S. Broadway, Yonkers. | 1895 |
| Kellogg, Chas. M. | 38 Clinton Ave., N., Rochester, | 1889 |
| KELLOGG, E. M. (1894) | 115 E. 37th, New York, Mhn., | 1866 |
| Kenyon, W. B. | Yonkers, | 1883 |
| King, Wm. Harvey | 64 W. 51st, New York, Mhn., | 1886 |
| Kingsley, O. D. | White Plains, | 1897 |
| Kinne, A. B. | Fayette Park, Syracuse, | 1882 |
| Kinne, E. O. | 516 Warren, Syracuse, | 1899 |
| Klots, E. D. | 132 W. 48th, New York, Mhn., | 1899 |
| Knapp, James C. | Geneva, | 1892 |
| Laidlaw, Alexander H. | 58 W. 53rd, New York, Mhn., | 1897 |
| Laidlaw, Geo. F. | 58 W. 53rd, New York, Mhn., | 1894 |
| Laird, F. F. | 720 Beacon, Los Angeles, Cal., | 1883 |
| Land, Joseph F. | 130 W. 126th, New York, Mhn., | 1888 |
| Lane, Charles E. | 289 Mill, Poughkeepsie, | 1893 |
| Lane, Irwin J. | 2 Church, Sing Sing, | 1892 |
| Lannin, Louise | 148 W. 85th, New York, Mhn., | 1895 |
| Latimer, W. C. | 351a Clinton, New York, Bkn., | 1884 |
| Lauer, C. F. | 241 Emerson Pl., New York, Bkn., | 1891 |
| Lawrence, J. B. | 289 Ninth, New York, Bkn., | 1894 |
| Lazarus, Geo. F. | 10 Caton Ave., New York, Bkn., | 1900 |
| Leal, Malcolm | 107 W. 48th, New York, Mhn., | 1888 |
| Lee, J. M. | 179 Lake Ave., Rochester, | 1884 |
| Leonard, Wm. H. | Tully, | 1899 |
| LeSeur, John W. | 207 E. Main, Batavia, | 1890 |
| Lewis, Fred D. | 188 Franklin, Buffalo, | 1893 |
| Lewis, F. Edward | Cambridge, | 1891 |
| Lewis, F. Park | 454 Franklin, Buffalo, | 1881 |
| Little, Wm. | Sherburne, | 1902 |
| Livezey, F. B. | 2807 N. Broad, Philadelphia, Pa., | 1898 |
| Lloyd, R. I. | 450 Ninth, New York, Bkn., | 1900 |
| Lount, Robert | 79 Fulton, Hempstead, | 1893 |
| Low, E. C. | Plattsburgh, | 1878 |
| MacCallum, John H. | 404 Monroe Ave., Rochester, | 1890 |
| Macfarland, R. L. | 53 Clinton Ave., New York, Jamaica, | 1898 |
| MacKenzie, John A. | Lima, | 1902 |
| Macy, C. S. | 103 W. 71st, New York, Mhn., | 1895 |
| Madden, J. D. | Sing Sing, | 1892 |
| Maeder, John G. | 304 E. 120th, New York, | 1900 |
| Martin, L. A. | 74 Exchange, Binghamton, | 1892 |
| Martin, T. J. | 279 North, Buffalo, | 1891 |
| Maycock, B. J. | 33 Allen, Buffalo, | 1893 |
| McDonald, W. O. | 117 W. 44th, New York, Mhn., | 1894 |

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| McDowell, Chas. | 110 W. 12th, New York, Mhn., | 1888 |
| McDowell, Geo. W. | 136 W. 130th, New York, Mhn., | 1892 |
| McGeoch, R. L. | Goshen, | 1901 |
| McGraw, D. H. | 96 Court, Binghamton, | 1899 |
| McKown, W. J. | 335 Hamilton, Albany, | 1895 |
| McMichael, A. R. | 969 Madison Ave., New York, Mhn., | 1891 |
| Mead, Walter Glover | 88 Front, Deposit, | 1902 |
| Mills, Walter Sands | 154 West 119th, New York, | 1900 |
| McMichael, D. A. | 67 W. 96th, New York, Mhn., | 1892 |
| McPherson, P. J. | Montour Falls, | 1899 |
| Merriam, H. E. | Owego, | 1894 |
| Meyer, O. N. | 171 E. 78th, New York, Mhn., | 1896 |
| Milbank, W. E. | 111 State, Albany, | 1879 |
| Miller, C. J. | Mount Kisco, | 1894 |
| Miller, John | 48 St. John's Pl., Buffalo, | 1891 |
| MILLER, R. E. (1898) | Oxford, | 1871 |
| Minton, H. B. | 165 Joralemon, New York, Bkn., | 1888 |
| Mitchell, J. J. | 242 Montgomery, Newburg, | 1880 |
| Moffat, John L. | 1136 Dean St., New York, Bkn., | 1883 |
| Montanye, W. De la | Rondout, Kingston, | 1891 |
| Moseley, G. T. | 202 Delaware Ave., Buffalo, | 1891 |
| Mossman, N. A. | 72d, cor. Broadway, N. Y., Mhn., | 1892 |
| Mott, O. H. (Lic.) | Fort Ann, | 1897 |
| Muncie, E. H. | 119 Macon, New York, Bkn., | 1890 |
| Muncie, Libbie H. | 119 Macon, New York, Bkn., | 1896 |
| Nash, E. B. | Cortland, | 1885 |
| Nead, W. M. | 205 State, Albany, | 1891 |
| Neefus, P. Wyckoff | 124 East Ave., Rochester, | 1896 |
| Neilson, H. S. | 63 W. 54th, New York, Mhn., | 1896 |
| Newman, Louis G. | Brewster, | 1901 |
| Nickelson, W. H. | Adams, | 1889 |
| Noble, E. H. | 410 E. Church, Elmira, | 1894 |
| Norton, A. B. | 16 W. 45th, New York, Mhn., | 1886 |
| Nott, F. J. | 29 E. 55th, New York, Mhn., | 1891 |
| Nottage, Rachel R. | 669 Macon, New York, Bkn., | 1900 |
| O'Connor, J. T. | 7 W. 42d, New York, Mhn., | 1889 |
| Ogden, E. G. | 10 E. 32d, New York, Mhn., | 1894 |
| Ogden, G. S. | 641 E. 28th, New York, Bkn., | 1898 |
| Ostrander, P. M. | Nunda, | 1894 |
| Ostrom, H. I. | 42 W. 48th, New York, Mhn., | 1886 |
| Otis, C. F. | Honeoye Falls, | 1890 |
| Otis, J. C. | 319 Mill, Poughkeepsie, | 1883 |
| Page, Roy A. | Geneseo, | 1895 |
| Paige, H. W. | 256 W. 57th, New York, Mhn., | 1892 |
| PAINE, H. M. (1891) | 67 N. Forsyth, Atlanta, Ga., | 1850 |
| Palmer, A. Worrall | 210 W. 57th, New York, Mhn., | 1899 |
| Parsons, Thomas | 33 Clinton Ave., S., Rochester, | 1896 |
| Partridge, B. S. | East Bloomfield, | 1889 |
| Pearsall, J. A. | Saratoga Springs, | 1882 |
| Pearsall, W. S. | 128 W. 78th, New York, Mhn., | 1896 |
| Peckham, Hattie C. Van Buren | 163 Halsey, New York, Bkn., | 1895 |
| Pettet, Isabella M. | 308 E. 15th, New York, Mhn., | 1897 |
| Pettit, A. R. | Patchogue, | 1891 |
| Phillips, R. Oliver | Yonkers, | 1891 |
| Phillips, R. E. | 21 Park Ave., Rochester, | 1898 |
| Pierce, Willard Ide | 64 W. 126th, New York, Mhn., | 1890 |
| Pierron, H. J. | 438 Greene Ave., New York, Bkn., | 1890 |
| Pierson, W. H. | 101 McDonough, New York, Bkn., | 1891 |
| Porter, E. H. | 181 W. 73d, New York, Mhn., | 1888 |
| Potter, Clarence A. | Gowanda State Hom. Hospital, | 1899 |
| Powel, Milton | 163 W. 76th, New York, Mhn., | 1902 |
| Powelson, A. P. | 102 Convent Ave., New York, Mhn., | 1897 |



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|---|---|---|
| Preston, H. G. | 54 Greene Ave., New York, Bkn., | 1875 |
| Proctor, W. H. | Bay Shore, L. I., | 1884 |
| Purdy, M. S. | Corning, | 1887 |
| Queen, L. A. | 261 W. 72d, New York, Mhn., | 1891 |
| Rambo, W. S. | 41 Sophia, Rochester, | 1893 |
| Randall, Edw. C. | Waterville, | 1902 |
| Rankin, Egbert C. | 226 Central Pk. S., New York, Mhn., | 1902 |
| Reynolds, W. U. | 320 Manhattan Ave., N. Y., Mhn., | 1888 |
| Richardson, A. J. | 39 E. 83d, New York, Mhn., | 1891 |
| Richardson, G. W. | 138 E. 79th, New York, Mhn., | 1891 |
| Ricker, Mrs. M. S. | 58 Lorimer, Rochester, | 1890 |
| Rieger, Joseph | 404 Central Ave., Dunkirk, | 1899 |
| Rink, Walter S. | 168 McDonough, New York, Bkn., | 1900 |
| Ritch, A. M. | 711 Putnam Ave., New York, Bkn., | 1891 |
| Ritch, Orando S. | 337a Macon, New York, Bkn., | 1889 |
| Ritchie, F. G. | 131 W. 47th, New York, Mhn., | 1894 |
| Robbins, A. Jerome | Mayville and Chautauqua, | 1902 |
| Roberts, D. J. | New Rochelle, | 1889 |
| Roberts, G. W. | 170 Central Park, New York, Mhn., | 1891 |
| Robinson, N. | 89 Halsey, New York, Bkn., | 1890 |
| Rockefeller, H. O. | 152 Jerome, New York, Bkn., | 1892 |
| Rodgers, Albert H. | Corning, | 1898 |
| Roe, J. F. | 25 Main, Binghamton, | 1897 |
| Roper, Frederick E. | 73 Broad, Norwich, | 1890 |
| Rounds, W. E. | 110 W. 49th, New York, Mhn., | 1889 |
| Rowley, C. A. | Victor, | 1890 |
| Royal, T. C. | Ballston Spa, | 1888 |
| Rudderow, E. D. | 145 W. 88th, New York, Mhn., | 1896 |
| Russell, H. Everett | 30 E. 74th, New York, Mhn., | 1892 |
| Russell, J. E. | 1036 Bedford Ave., New York, Bkn., | 1889 |
| Sanders, L. J. | 421 Monroe Ave., Rochester, | 1897 |
| Santway, F. L. | Theresa, | 1896 |
| Schall, J. Hubley | 141 St. Mark's Ave., N. Y., Bkn., | 1901 |
| Schenck, H. D. | 241 McDonough, New York, Bkn., | 1887 |
| Schley, J. M. | 32 W. 49th, New York, Mhn., | 1889 |
| Schumann, C. | Delhi, | 1892 |
| Schwilk, Elisha T. | 228 Clinton Ave., Albany, | 1900 |
| Scott, W. H. | 104 W. 44th, New York, Mhn., | 1888 |
| Scudder, N. C. | 506 N. James, Rome, | 1898 |
| SEARLE, W. S. (1894) | 62 Clark, New York, Bkn., | 1865 |
| Seitz, F. B. | 21 North, Buffalo, | 1897 |
| Severance, B. W. | Gouverneur, | 1897 |
| Seward, F. W. | Goshen, | 1891 |
| Seward, F. W., Jr. | Goshen, | 1901 |
| Seward, John Perry | 200 W. 70th, New York, Mhn., | 1902 |
| Seymour, G. W. | Westfield, | 1883 |
| Shattuck, J. W. M. | Westport, | 1897 |
| Shaw, J. C. | Hoosick Falls, | 1885 |
| Sheldon, Jay W. | 501 Fayette Park, Syracuse, | 1885 |
| Shelton, G. G. | 521 Madison Ave., N. Y., Mhn., | 1886 |
| Shepard, G. A. | Broadway and 52d, N. Y., Mhn., | 1892 |
| Sherman, I. P. | 59 W. 90th, New York, Mhn., | 1894 |
| Sherman, LeRoy B. | 355 W. 14th, New York, Mhn., | 1902 |
| Sherwood, Bradford Wyckoff | 1117 S. Salina, Syracuse, | 1901 |
| Simmons, D. | 1188 Dean, New York, Bkn., | 1884 |
| Simmons, R. S. | 129 E. 59th, New York, Mhn., | 1891 |
| Simmons, Silas S. | Susquehanna, Penn., | 1885 |
| Simonds, E. A. | Carthage, | 1902 |
| Simonson, J. T. | 46 W. 85th, New York, Mhn., | 1901 |
| Simpson, E. D. | 320 W. 115th, New York, Mhn., | 1899 |
| Skinner, S. W. | Le Roy, | 1887 |
| Slaught, J. E. | Warsaw, | 188- |

| | | |
|---|---|---|
| Smith, F. R. | 89 Plymouth Ave., Rochester, | 1893 |
| Smith, Geo. H., Jr. | 758 Greene Ave., Brooklyn, | 1902 |
| Smith, Geo. H. | 921 Greene Ave., Brooklyn, | 1902 |
| Smith, O. W. | Union Springs, | 1884 |
| Smith, St. Clair | 25 W. 50th, New York, Mhn., | 1891 |
| SMITH, T. F. (1894) | 264 Lenox Ave., New York, Mhn., | 1871 |
| Snow, S. R. | 267 Alexander, Rochester, | 1893 |
| Snyder, E. E. | 27 Main, Binghamton, | 1883 |
| SOUTHWICK, A. B. (1898) | Rome, | 1871 |
| SOUTHWICK, D. E. (1900) | Ogdensburgh, | 1867 |
| Spencer, T. D. | 24 Union, S., Rochester, | 1884 |
| Spire, C. E. | Clyde, | 1898 |
| Spoor, D. E. | N. Granville, | 1883 |
| Stanton, L. M. | 132 W. 58th, New York, Mhn., | 1895 |
| Stearns, G. R. | 201 Linwood Ave., Buffalo, | 1893 |
| Stevens, D. D. | 49 83rd, New York, Mhn., | 1894 |
| Stewart, J. A. | 1030 Bedford Ave., N. Y., Bkn., | 1892 |
| Stewart, W. A. | Dupont Circle, Washington, D. C., | 1895 |
| Stiles, H. R. | 113 William, New York, Mhn., | 1885 |
| Storer, J. H. | 30 Edgecomb Ave., N. Y., Mhn., | 1892 |
| Street, H. E. | 98 Brooklyn Ave., New York, Bkn., | 1894 |
| Strong, C. H. | 410 Nat. Union Bldg., Toledo, O., | 1892 |
| Stumpf, D. B. | 693 Ellicott, Buffalo, | 1885 |
| Sumner, C. R. | 33 Clinton Ave., S., Rochester, | 1882 |
| Sweeting, W. H. | Savannah, | 1890 |
| Swett, Emily F. | Medina, | 1892 |
| Swift, E. P. | 170 W. 88th, New York, Mhn., | 1888 |
| Sword, G. P. | Huntington, L. I., | 1900 |
| Talmage, S. | 22 Schermerhorn, New York, Bkn., | 1899 |
| Teets, C. E. | 37 W. 39th, New York, Mhn., | 1888 |
| TERRY, M. O. (1902) | 196 Genesee, Utica, | 1876 |
| Thatcher, E. P. | Main St., Newark, | 1893 |
| Thompson, V. | 56 W. 21st, New York, Mhn., | 1888 |
| Thorpe, Jarvis L. | Clyde, | 1902 |
| Throop, A. P. | Port Gibson, | 1874 |
| Thurber, T. J. | 157 Plymouth Ave., Rochester, | 1889 |
| Townsend, Charles W. | 152 W. 48th, New York, Mhn., | 1902 |
| Townsend, Irving | 67 W. 46th, New York, Mhn., | 1891 |
| Travers, Osmond J. | 85 Phila St., Saratoga Springs, | 1902 |
| Trotter, R. R. | Yonkers, | 1890 |
| Turner, T. S. | 231 Chenango, Binghamton, | 1897 |
| Tuttle, E. G. | 61 W. 51st, New York, Mhn., | 1892 |
| Tytler, G. E. | 113 W. 126th, New York, Mhn., | 1889 |
| Van Buren, B. L. (Lic.) | Lebanon Springs, | 1897 |
| Van Denburg, M. W. | 107 Union Ave., Mount Vernon, | 1887 |
| Van den Burg, W. H. | 32 W. 49th, New York, Mhn., | 1897 |
| Van Derwerker, H. W. | Sandy Hill, | 1897 |
| Van Loon, A. B. | 50 Eagle, Albany, | 1894 |
| Van Ostrand, D. G. | Candor, | 1899 |
| Van Schoonhoven, C. S. | 1060 Lafayette Ave., N. Y., Mhn., | 1902 |
| Vehslage, S. H. | 117 W. 43d, New York, Mhn., | 1891 |
| Vibbard, Arthur A. | Sloanville, | 1901 |
| Vincent, Stanley | 262 Main, Catskill, | 1899 |
| Von Bonnewitz, Orlando R. | 143 W. 122nd, New York, Mhn., | 1902 |
| Von der Lühe, A. | 245 Hooper, New York, Bkn., | 1883 |
| Wait, Phoebe J. B. | 34th and 9th Ave., New York, Mhn., | 1900 |
| Waite, Annie E. Langworthy | 1381 Boston Ave., New York, Mhn., | 1900 |
| Waldo, H. L. | 1834 Fifth Ave., Troy, | 1879 |
| Walrad, C. B. | Johnstown, | 1889 |
| Ward, C. A. | 33 Court, Binghamton, | 1890 |
| Warner, A. G. | 19 Schermerhorn, New York, Bkn., | 1888 |
| Warner, F. P. | Canandaigua, | 1893 |



| | | |
|---|---|---|
| WATSON, W. H. (1891) | 270 Genesee, Utica, | 1869 |
| Weed, R. M. | New Rochelle, | 1802 |
| Wemmel, Andrew A. | 2600 Atlantic Ave., New York, Bkn., | 1902 |
| Wetmore, J. McE. | 43 W. 54th, New York, Mhn., | 1892 |
| White, A. Lenora | 151 W. 46th, New York, Mhn., | 1892 |
| White, Benjamin Richard | Honeoye Falls, | 1902 |
| White, J. C. | Portchester, | 1891 |
| Wiggins, T. C. | 12 Verona Pl., New York, Mhn., | 1894 |
| Wilcox, DeWitt G. | 597 Elmwood Ave., Buffalo, | 1887 |
| Wilcox, Sidney F. | 51 W. 52d, New York, Mhn., | 1891 |
| Willcox, Geo. W. | Hamilton, | 1902 |
| Williams, F. F. | 6 Goodrich, Canton, | 1892 |
| Williams, T. C. | 118 E. 19th, New York, Mhn., | 1892 |
| Williamson, B. | Friendship, | 1893 |
| Willis, H. | 569 Monroe, New York, Bkn., | 1892 |
| Winchell, W. B. | 137 Berkeley Pl., New York, Bkn., | 1889 |
| Winter, Chas. S. | 107 Court, Binghamton, | 1902 |
| Wolcott, E. H. | 57 Union, Rochester, | 1886 |
| Woodman, Robert C. | Middletown, | 1900 |
| Woodruff, A. J. | Babylon, | 1891 |
| Wright, Amelia | 295 Glen, Glens Falls, | 1902 |
| Wright, J. G. | 363 Eleventh, New York, Bkn., | 1900 |
| Zeckhaasen, Harry | 25 Seventh, New York, Mhn., | 1902 |
| Zwetsch, J. D. | Gowanda, | 1883 |

## DELEGATE MEMBERS.

### CLASS 3.

*Terms expire with the Annual Meeting in 1903.*

| | |
|---|---|
| *Albany County,* | 4—Spoor, W. D., 168 Lafayette, Schenectady.<br>Marshall, B. E., 106 Central Ave., Albany.<br>Towne, F. L., Schenectady.<br>Bailey, C. L., Albany. |
| *Chenango County,* | 1—Ganow, G. J., Oxford. |
| *Madison County,* | 1— |
| *Montgomery County,* | 1—Knott, Harriet A., Gloversville. |
| *Onondaga County,* | 3—Chaffee, R. W., 1701 Genesee, Syracuse.<br>Keeler, E. E., 452 Salina, Syracuse.<br>Lukens, C. M., 117 E. Jefferson, Syracuse. |
| *Ontario County,* | 1—Mitchel, C. T., Canandaigua. |
| *Massachusetts Medical Society Delegates,* | 2—N. Emmons Paine, W. Newton, Mass.<br>J. P. Rand, Monson, Mass. |

### CLASS A.

*Terms expire with the Annual Meeting in 1905.*

| | |
|---|---|
| *Broome County,* | 1—Bailey, D. P., 41 Court, Binghamton. |
| *Dutchess County,* | 2—Peckham, A. L., Poughkeepsie.<br>Embley, Thomas W., Fishkill. |
| *Jefferson County,* | 2— |
| *Monroe County,* | 4—Button, L. L., 265 Alexander, Rochester.<br>Carman, W. B., 23 Upton Park, Rochester.<br>Whittleton, E. J., Webster.<br>Winans, W. W., 33 Clinton Ave., S., Rochester. |

# DIRECTORY

OF THE

# HOMŒOPATHIC PRACTITIONERS

OF THE

# STATE OF NEW YORK.

## DECEMBER, 1902.

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* Permanent Member of State Society.
† Delegate Member of State Society.
‡ Member of County Society.

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A painstaking effort has been made to produce a directory as nearly correct as possible. Early in the year personal letters were sent to one or more representatives in each county asking for a correct and full list of homœopathic physicians in his respective county. With the exception of three or four instances these letters brought full reports. These reports were compared with the standard medical directories and when a name appeared in the latter which did not appear in the reports, inquiry was made concerning such name.

In accordance with the wishes of the American Institute of Homœopathy notice of good openings for homœopathists are solicited and will be published.

The thanks of the Society are due (and are hereby acknowledged) to those who have afforded aid in the compilation of this directory.

All who notice errors will confer a favor upon the profession at large by promptly sending corrections and additions to

DE WITT G. WILCOX,
*Secretary.*

597 Elmwood Avenue,
Buffalo, New York.



The directory this year shows 1329 homœopathic doctors in 338 towns of 59 counties, distributed as follows:

| | | | | | |
|---|---|---|---|---|---|
| ‡Albany | 21 | ‡Jefferson | 20 | Richmond | 4 |
| Allegany | 7 | ‡Kings | 191 | Rockland | 3 |
| ‡Broome | 18 | Lewis | 2 | St. Lawrence | 16 |
| Cattaraugus | 9 | Livingston | 12 | Saratoga | 10 |
| Cayuga | 19 | ‡Madison | 10 | Schenectady | 8 |
| Chautauqua | 20 | ‡Monroe | 78 | Schuyler | 6 |
| Chemung | 12 | ‡Montgomery | 5 | Seneca | 5 |
| ‡Chenango | 7 | Nassau | 3 | Steuben | 11 |
| Clinton | 2 | ‡New York | 376 | Suffolk | 11 |
| Columbia | 7 | Niagara | 17 | Sullivan | 3 |
| Cortland | 7 | Oneida | 20 | Tioga | 8 |
| Delaware | 5 | ‡Onondaga | 49 | Tompkins | 15 |
| ‡Dutchess | 11 | ‡Ontario | 15 | Ulster | 12 |
| Erie | 59 | ‡Orange | 27 | Warren | 8 |
| Essex | 9 | Orleans | 5 | Washington | 15 |
| Franklin | 2 | ‡Oswego | 9 | Wayne | 17 |
| Fulton | 6 | Otsego | 9 | ‡Westchester | 37 |
| Genesee | 11 | Putnam | 4 | Wyoming | 9 |
| Greene | 4 | Queens | 11 | Yates | 5 |
| Herkimer | 5 | Rensselaer | 21 | | |

‡County Society.

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## TOWN INDEX.

Coxsackie ..... Greene
Corning ..... Steuben
Cornwall-on-Hudson ..... Orange
Cortland ..... Cortland
Crown Point ..... Essex
Cuba ..... Allegany
Dansville ..... Livingston
De Kalb Junction ..... St. Lawrence
Delhi ..... Delaware
Deposit ..... Broome
De Ruyter ..... Madison
Dobbs Ferry ..... Westchester
Dundee ..... Yates
Dunkirk ..... Chautauqua
Eagle Bridge ..... Rensselaer
East Aurora ..... Erie
East Bloomfield ..... Ontario
East Greenbush ..... Rensselaer
East Hamilton ..... Madison
East Hamlin ..... Monroe
Easton ..... Washington
Elba ..... Genesee
Elbridge ..... Onondaga
Elizabethtown ..... Essex
Ellenville ..... Ulster
Elmira ..... Chemung
Essex ..... Essex
Etna ..... Tompkins
Fairport ..... Monroe
Farmer Village ..... Seneca
Fayetteville ..... Onondaga
Flushing ..... Queens
Fonda ..... Montgomery
Fort Edward ..... Washington
Fort Plain ..... Montgomery
Franklin ..... Delaware
Freeville ..... Tompkins
Fredonia ..... Chautauqua
Friendship ..... Allegany
Fulton ..... Oswego
Galway ..... Saratoga
Gasport ..... Niagara
Geneseo ..... Livingston
Geneva ..... Ontario
Genoa ..... Cayuga
Glen Cove ..... Nassau
Glens Falls ..... Warren
Glenhead ..... Nassau
Gloversville ..... Fulton
Goshen ..... Orange
Gouverneur ..... St. Lawrence
Gowanda ..... Cattaraugus
Granville ..... Washington
Greenbush ..... Rensselaer
Greene ..... Chenango
Greenport ..... Suffolk
Greenwich ..... Washington
Groton ..... Tompkins
Hamburg ..... Erie
Hamilton ..... Madison
Hammondsport ..... Steuben
Hartwick ..... Otsego
Hempstead ..... Nassau
Herkimer ..... Herkimer
Heuvelton ..... St. Lawrence
Holland ..... Erie
Homer ..... Cortland
Honeoye Falls ..... Monroe
Hoosick ..... Rensselaer
Hoosick Falls ..... Rensselaer
Hornellsville ..... Steuben
Hudson ..... Columbia
Huntington ..... Suffolk
Italy Hollow ..... Yates
Ithaca ..... Tompkins
Jamaica ..... Queens
Jamestown ..... Chautauqua
Jay ..... Essex
Johnsonville ..... Rensselaer
Johnstown ..... Fulton
Jordan ..... Onondaga
Keeseville ..... Essex
Kinderhook ..... Columbia
Kingston ..... Ulster
Lafayette ..... Onondaga
Lansingburgh ..... Rensselaer
Lebanon Springs ..... Columbia
Le Roy ..... Genesee
Liberty ..... Sullivan
Lily Dale ..... Chautauqua
Lima ..... Livingston
Little Falls ..... Herkimer
Liverpool ..... Onondaga
Livonia ..... Livingston
Livonia Station ..... Livingston
Lockport ..... Niagara
Logan ..... Schuyler
Long Island City ..... Queens
Longeddy ..... Sullivan
Lowville ..... Lewis
Ludlowville ..... Tompkins
Lysander ..... Onondaga
Lyons ..... Wayne
Madison ..... Madison
Malone ..... Franklin
Mamaroneck ..... Westchester
Mannsville ..... Jefferson
Marcellus ..... Onondaga
Margaretville ..... Delaware
Marion ..... Wayne
Massena ..... St. Lawrence
Matteawan ..... Dutchess
Mayfield ..... Fulton
Mechanicsville ..... Saratoga
Mecklenburgh ..... Schuyler
Medina ..... Orleans
Medway ..... Greene
Memphis ..... Onondaga
Mexico ..... Oswego
Middleport ..... Niagara
Middletown ..... Orange
Milbrook ..... Dutchess



Millport ..... Chemung
Modena ..... Ulster
Mohawk ..... Herkimer
Montour Falls ..... Schuyler
Moriah ..... Essex
Moravia ..... Cayuga
Morris ..... Otsego
Mount Kisco ..... Westchester
Mount Vernon ..... Westchester
Mt. Morris ..... Livingston
Naples ..... Ontario
Nelsonville ..... Westchester
Newark ..... Wayne
Newark Valley ..... Tioga
New Berlin ..... Chenango
New Brighton ..... Richmond
Newburgh ..... Orange
New Paltz ..... Ulster
New Rochelle ..... Westchester
New Scotland ..... Albany
New York ..... New York
North Branch ..... Sullivan
North Brookfield ..... Madison
Niagara Falls ..... Niagara
North Granville ..... Washington
North Tonawanda ..... Niagara
North Tarrytown ..... Westchester
Norwich ..... Chenango
Norwood ..... St. Lawrence
Nunda ..... Livingston
Nyack ..... Rockland
Ogdensburg ..... St. Lawrence
Olean ..... Cattaraugus
Oneida ..... Madison
Oneonta ..... Otsego
Ontario ..... Wayne
Oswego ..... Oswego
Otego ..... Otsego
Owasco ..... Cayuga
Owego ..... Tioga
Oxford ..... Chenango
Palmyra ..... Wayne
Panama ..... Chautauqua
Patchogue ..... Suffolk
Patterson ..... Putnam
Pavilion ..... Genesee
Peekskill ..... Westchester
Penfield ..... Monroe
Penn Yan ..... Yates
Perry ..... Wyoming
Phelps ..... Ontario
Philadelphia ..... Jefferson
Phœnix ..... Oswego
Pike ..... Wyoming
Pittsford ..... Monroe
Plattsburg ..... Clinton
Pleasantville ..... Westchester
Port Chester ..... Westchester
Port Gibson ..... Ontario
Port Jervis ..... Orange
Potsdam ..... St. Lawrence
Poughkeepsie ..... Dutchess
Randolph ..... Cattaraugus
Redwood ..... Jefferson
Rhinebeck ..... Dutchess
Richfield Springs ..... Otsego
Riverhead ..... Suffolk
Rochester ..... Monroe
Rome ..... Oneida
Reed Corners ..... Ontario
Rosendale ..... Ulster
Rondout ..... Ulster
Round Lake ..... Saratoga
Salamanca ..... Cattaraugus
Salisbury Center ..... Herkimer
Salem ..... Washington
Salt Point ..... Dutchess
Sandy Hill ..... Washington
Saranac Lake ..... Franklin
Saratoga Springs ..... Saratoga
Saugerties ..... Ulster
Savannah ..... Wayne
Schenectady ..... Schenectady
Scott ..... Cortland
Seely Creek ..... Chemung
Seneca Falls ..... Seneca
Sherburne ..... Chenango
Shortsville ..... Ontario
Shrub Oak ..... Westchester
Silver Creek ..... Chautauqua
Sinclairville ..... Chautauqua
Sing Sing ..... Westchester
Skaneateles ..... Onondaga
Slate Hill ..... Orange
Sloansville ..... Schuyler
Smithville Flats ..... Chenango
Sodus ..... Wayne
South Butler ..... Wayne
South Byron ..... Genesee
South Greece ..... Monroe
South Hampton ..... Suffolk
Southold ..... Suffolk
Spencertown ..... Clinton
Springville ..... Erie
Spafford ..... Onondaga
Springwater ..... Livingston
Syracuse ..... Onondaga
Theresa ..... Jefferson
Ticonderoga ..... Essex
Tonawanda ..... Erie
Tottenville ..... Richmond
Trenton ..... Oneida
Troy ..... Rensselaer
Trumansburgh ..... Tompkins
Tully ..... Onondaga
Unadilla ..... Otsego
Union Springs ..... Cayuga
Union ..... Broome
Utica ..... Oneida
Victor ..... Ontario
Walden ..... Orange
Walton ..... Delaware

| | |
|---|---|
| Walworth | Wayne |
| Wappingers Falls | Dutchess |
| Warner's | Onondaga |
| Warsaw | Wyoming |
| Warwick | Orange |
| Washingtonville | Orange |
| Waterford | Saratoga |
| Waterloo | Seneca |
| Watertown | Jefferson |
| Waterville | Oneida |
| Watervliet | Albany |
| Watkins | Schuyler |
| Waverly | Tioga |
| Wayland | Steuben |
| Webster | Monroe |
| Weedsport | Cayuga |
| Wellsville | Allegany |
| Westbury Station | Queens |
| Westfield | Chautauqua |
| West New Brighton | Richmond |
| Westport | Essex |
| West Salamanca | Cattaraugus |
| Whitehall | Washington |
| West Winfield | Herkimer |
| White Plains | Westchester |
| Williamsbridge | Westchester |
| Williamson | Wayne |
| Wilson | Niagara |
| Wolcott | Wayne |
| Woodhaven | Kings |
| Wyoming | Wyoming |
| Yonkers | Westchester |
| Yorkshire | Cattaraugus |

## OPENINGS FOR PRACTICE.

| County. | Location. | Reference. |
|---|---|---|
| *Allegany,* | ALFRED, | Dr. DeW. G. Wilcox, Buffalo. |
| *Broome,* | WHITNEY'S POINT, | Dr. E. B. Nash, Cortland. |
| *Cayuga,* | PORT BYRON, | Dr. C. A. Gwynn, Auburn. |
| *Chautauqua,* | BROCTON, | Dr. Jos. Rieger, Dunkirk. |
| *Chautauqua,* | SHERMAN, | Dr. A. S. Couch, Fredonia. |
| *Chemung,* | HORSEHEADS, | Dr. F. W. Adriance, Elmira. |
| *Chemung,* | ELMIRA, | Dr. F. W. Adriance, Elmira. |
| *Columbia,* | VALATIE, | Dr. C. P. Cook, Hudson. |
| *Columbia,* | KINDERHOOK | Dr. C. P. Cook, Hudson. |
| *Cortland,* | MARATHON, | Dr. E. B. Nash, Cortland. |
| *Cortland,* | CINCINNATUS, | Dr. E. B. Nash, Cortland. |
| *Delaware,* | FRANKLIN, | Dr. C. Schumann, Delhi. |
| *Delaware,* | STAMFORD, | Dr. C. Schumann, Delhi. |
| *Genesee,* | CORFU, | Dr. J. W. LeSeur, Batavia. |
| *Herkimer,* | ILION, | Dr. L. L. Brainard, Little Falls. |
| *Onondaga,* | JAMESVILLE, | Dr. W. L. Hartman, Syracuse. |
| *Onondaga,* | ONATIVIA, | Dr. W. L. Hartman, Syracuse. |
| *Onondaga,* | BALDWINSVILLE, | Dr. W. L. Hartman, Syracuse. |
| *Onondaga,* | MANLIUS, | Dr. L. B. Richards, Oswego. |
| *Orange,* | CORNWALL-ON-HUDSON, | Dr. M. C. Ashley, Middletown. |
| *Orange,* | MONROE, | Dr. M. C. Ashley, Middletown. |
| *Seneca,* | WATERLOO, | Dr. R. B. Covert, Seneca Falls. |
| *Seneca,* | OVID, | Dr. E. W. Bryan, Corning. |
| *Schuyler,* | BEAVER DAMS, | Dr. M. S. Purdy, Corning. |
| *Suffolk,* | RIVERHEAD, | Dr. A. R. Pettit, Patchogue. |
| *Tompkins,* | DRYDEN, | Dr. E. B. Nash, Cortland. |
| *Wyoming,* | ELLICOTTVILLE, | Dr. W. B. Gifford, Attica. |



### ALBANY COUNTY.

*Annual Meeting, Albany, second Thursday in January. President, J. I. Dowling; Vice-President, H. L. Towne; Secretary and Treasurer, Frederick J. Cox.*

ALBANY.
†Bailey, C. L., 281 Clinton Ave.
††Blessing, Elmer A., 157 Hamilton.
*‡Carroll, Stephen H., 234 State.
†*Cochrane, H. D., 59 Eagle.
*‡Cox, Edward G., 261 State.
*‡Cox, Frederick J., 109 State.
*‡Cox, Geo. A., 80 S. Swan.
*‡Dowling, J. Ivimey, 223 State.
*‡Gorham, G. E., 218 State.
*‡Hunting, Nelson, 155 Hamilton.
*‡McKown, Wm. J., 335 Hamilton.
†Marshall, B. E., 106 Central Ave.
*‡Milbank, W. E., 111 State.
*‡Nead, W. M., 205 State.
*Schwilk, Elisha T., 238 Clinton Av.
*‡Van Loon, Arthur B., 50 Eagle.
COHOES.
Mott, Albert, 105 Mohawk.
‡Campbell, Wm. M.
NEW SCOTLAND.—‡Fitch, J. H.
WATERVLIET.
Van Denbergh, Fred P., 220 23d.
Payne, Chas. O.

### ALLEGANY COUNTY.

*No Society.*

ALMOND.—Farnum, Llewellyn, D.
BELFAST.—*Chamberlain, J. H.
Todd, W. S.
BELMONT.—*Hardy, Wm. J.
Paul, W. K.
FRIENDSHIP.
*Williamson, Bemsley.
WELLSVILLE.—Gish, C. L.

### BROOME COUNTY.

*Annual Meeting, Binghamton, third Wednesday in June. President, C. A. Ward; Vice-Presidents, A. J. Butterfield, C. S. Winters; Secretary and Treasurer, J. B. Bates.*

BINGHAMTON.
‡Bates, J. B., 29 Arthur.
††Bailey, D. P., 41 Court.
Butterfield, Alfred J.
*‡Corwin, Elizabeth, 104 Main.
‡Hand, Geo. F., 79 Court.
*‡Jenkins, Geo. H., 139 Main.
*‡Martin, Lynn A., 74 Exchange.
*‡McGraw, De Witt H., 3 and 4 Hagaman Building.
Raymond, H. L., 259 Chenango.
*‡Roe, J. F., 25 Main.
*‡Snyder, E. E., 27 Main.
‡Stoutenburg, A. W., 27 Main.
*Turner, T. S., 231 Chenango.
*‡Ward, Charles A., 33 Court.
‡Ward, W. F., 33 Court.
*‡Winters, C. S., 122 Court.
DEPOSIT.
*Mead, Walter G., 88 Front.
UNION.—Knapp, Theodore P.

### CATTARAUGUS COUNTY.

*No Society.*

OLEAN.
*Hibbard, DeVere M., 112 Berry.
Jepson, Mary B.
Watts, T. E.
GOWANDA.
*Zwetsch, J. D., 23 Main.
RANDOLPH.—Babcock, A. H.
SALAMANCA.—Martin, O. S.
Bourne, Philip H.
WEST SALAMANCA.
Baker, Daniel P.
YORKSHIRE.—Sovereign, Baxter.

### CAYUGA COUNTY.

*No Society.*

AUBURN.
*Babbitt, Otis H., 178 Genesee.
Baker, A. E., 55 Franklin.
Bresee, Chas. H., 1 Cayuga.
*Frye, M. M., 167 Genesee.
*Gwynn, Charles A., 13 Grover.
*Gwynn, W. M., 14 Grover.
Heartwell, W. B., 78 Genesee.
Hyatt, F. M., 49 E. Genesee.
Robinson, Robt. W., 30 Court.
Smith, Truman K., 173 Genesee.
Swift, Chas. L., 159 VanAnden.
Howland, Josephine.
CATO.—Evarts, Edgar S.
GENOA.—Skinner, J. W.
MORAVIA.—Cook, Wm. C.
OWASCO.—Ford, N. B.
UNION SPRINGS.—Alleman, J. J.
Smith, Oran W.
WEEDSPORT.—*‡Barnes, C. F.

### CHAUTAUQUA COUNTY.

*No Society.*

CHAUTAUQUA.—*Robbins, A. J.
DUNKIRK.
*Rieger, Jos., 404 Central Ave.
Vosburg, W., 327 Lion.
FREDONIA.
*Couch, Asa S.
Dods, A. Wilson.
Landon, Elizabeth T.
Prish, J. W.
JAMESTOWN.
Lockwood, Benj. F.
Morgan, Laura.

Neville, Henry.
Ormes, F. D., 320 Main.
Ormes, F. D., Jr., 320 Main.
Rice, Alvin B., Main and Third.
Scott, John W.
Ward, Alva F.
Young, Chas. H.
LILLY DALE.—Hyde, E. C.
MAYVILLE.—*Robbins, A. J.
PANAMA.—Young, A. D.
SILVER CREEK.—Cole, W. W.
WESTFIELD.—*Seymour, G. W.

### CHEMUNG COUNTY.

*No Society.*

BIG FLATS.—Davis, D. L.
CATLIN.—Thorn, Sarah Eddy.
ELMIRA.
*Adriance, F. W., 306 Lake.
*DeCamp, F. H., 332 E. Water.
Easton, James D.
*Eddy, Ermina C., 500 William.
*Gregory, G. W., 370 W. Church.
*Howland, Reeve B., 306 Lake.
Jenks, R. B.
*Noble, E. H., 410 E. Church.
Platner, Marion M.
SEELY CREEK.—Robbins, A. F.

### CHENANGO COUNTY.

*Annual Meeting, third Tuesday in January; Semi-Annual, third Tuesday in June. President, R. E. Miller; Secretary and Treasurer, F. E. Roper.*

AFTON.—C. W. Hakes.
GREENE.—*Guy, C. N.
NEW BERLIN.—‡Tuttle, Ella M.
NORWICH.
*‡Roper, F. E., 73 Broad.
OXFORD.—*‡Miller, R. E.
††Ganow, G. J.
SHERBURNE.—*‡Little, Wm.

### CLINTON COUNTY.

PLATTSBURGH.—Farnsworth, F. S.
*Low, Elliot C., Oak, cor. Brinkerhoff.

### COLUMBIA COUNTY.

*No Society.*

CHATHAM.—Clark, Mary.
Mosher, Charles L.
HUDSON.—*Cook, C. P.
Tracy, A. M.
KINDERHOOK.—Green, James.
LEBANON SPRINGS.
*Van Buren, B. L.
SPENCERTOWN.—Mesick, J. C.

### CORTLAND COUNTY.

*No Society.*

CORTLAND.
*Johnson, H. P., 15 Port Watson.
*Nash, E. B., 28 Clinton Ave.
Santee, E. M., 20 Groton Ave.
Spalding, Julia A.
HOMER.
Potter, Leman W., 10 S. Main.
Goodell, R. A., 41 N. Main.
SCOTT.—*Ball, Halsey J.

### DELAWARE COUNTY.

*No Society.*

DELHI.—*Schumann, Carl.
FRANKLIN.—Foote, J. H.
MARGARETVILLE.
Telford, John W.
WALTON.—Mowbray, J. L.
St. John, A. H.

### DUTCHESS COUNTY.

*Annual Meeting, Poughkeepsie, third Tuesday in October. President, J. H. Otis; Vice-President, H. Reid Hawley; Secretary and Treasurer, A. L. Peckham.*

MATTEAWAN.—Dawson, J. G.
MILLBROOK.—‡Jacobus, S. J.
POUGHKEEPSIE.
‡Howland, Anna C., 2 S. Hamilton.
*‡Lane, Chas E., 289 Mill.
*‡Otis, John C., 319 Mill.
‡Otis, John H., 319 Mill.
†Peckham, A. L., 31 Cannon.
RHINEBECK.
Asher, Rutson E. (Retired.)
‡Godell, J. L.
SALT POINT.—*‡Angel, Milton H.
WAPPINGER'S FALLS.
‡Baxter, William.

### ERIE COUNTY.

*No Society.*

AKRON.—Parker, Frank D.
BUFFALO.
Babcock, C. W., 151 Allen.
Bæthig, H., 350 Pennsylvania.
*Beals, Herbert, 188 Franklin.
Bodenbender, Edward G., 660 Walden Ave.
Bodenbender, N. W., 804 Jefferson.
Broardt, Peter, 394 Adams.
Bull, Alex. T., 184 Franklin.
*Carpenter, A. D., 1118 Genesee.
Carter, P. L., 35 Lafayette Ave.
*Chadwick, J. G., 382 Franklin.
*Cook, J. T., 636 Delaware Ave.



*Critchlow, George R., 505 Norwood Ave.
Curtis, A. M., 780 W. Ferry.
Dean, D. A., 89 Riley.
*Decker, W. M., 242 Ashland.
*Erb, Peter, 32-34 Palace Arcade.
*Foster, Hubbard A., 3 St. John's Pl.
Frost, H. C., 212 Delaware Ave.
Groesbeck, Frederick B., 597 Elmwood Ave.
Halbert, J. S., 459 Franklin.
Hussey, E. P., 493 Porter Ave.
*Lewis, Fred D., 188 Franklin.
*Lewis, F. Park, 454 Franklin.
Linquist, M. F., The Kenilworth, Elmwood and Anderson Pl.
Long, W. E., 892 Ellicott Square.
McCrea, Philip A., 448 Franklin.
McGill, W. D., 296 S. Division.
Marcy, W. H., 1148 Main.
*Martin, Truman J., 279 North.
*Maycock, B. J., 33 Allen.
*Miller, John, 48 St. John's Pl.
Morris, Sarah, 2079 Main.
*Moseley, G. T., 202 Delaware Ave.
McClellan, A. I., 72 York.
Parmenter, W. L., 931 Prospect Av.
Reed, Mark E., 24 Como Ave.
Roberts, Burt B., 58 Palace Arcade.
Root, Reuben M., 40 Krettner.
Salter, A. E., 20 Edna Pl.
Seaman, C. W., 232 Hoyt.
*Seitz, F. B., 21 North.
Spillsbury, F. C., 502 Niagara.
*Stearns, G. R., 201 Linwood Ave.
*Stumpf, Daniel B., 693 Ellicott.
Wage, John F., 414 Seneca.
*Wilcox, DeWitt G., 597 Elmwood Ave.
Wild, Geo. W., 345 Main.
Wilder, Rose C., 247 W. Utica.
CLARENCE CENTER.
Lehman, J. S.
GOWANDA STATE HOMŒOPATHIC HOSPITAL.
*Adams, G. F.
*Arthur, D. H.
*Potter, Clarence A.
EAST AURORA.—Mitchell, A. L.
HAMBURG.—Barnes, Francis.
HOLLAND.—Noble, W. A.
SPRINGVILLE.—Caulkins, Frank.
TONAWANDA.—Blighton, W. V. R.
Simpson, John R.

### ESSEX COUNTY.

*No Society.*

CROWN POINT.—Eaton, Erwin R.
ELIZABETHTOWN.—Wasson, T. A.
ESSEX.—Chase, Edwin R.
JAY.—Toby, C. McV.
KEESEVILLE.—Pope, Willis G.
Severance, Karl.
MORIAH.—Powell, George W.
TICONDEROGA.—Bond, George W.
WESTPORT.—*Shattuck, J. W. M.

### FRANKLIN COUNTY.

MALONE.—Belding, D. K.
SARANAC LAKE.
*Hallock, J. Henry.

### FULTON COUNTY.

(‡*Montgomery County Society.*)

GLOVERSVILLE.
Bissell, D. A.
*‡Eisenbrey, E. H.
*‡Garnsey, W. S., 93 N. Main.
Tuck, Arthur E.
JOHNSTOWN.—*‡Walrad, C. B.
MAYFIELD.—Ingalls, Gilbert.

### GENESEE COUNTY.

*No Society.*

ELBA.—Lewis, J. M.
BATAVIA.
Baker, John W., 5 Bank.
*Conklin, R. C., Ellicott Ave.
Fish, Julia F.
*Hutchins, H. S., 215 E. Main.
*LeSeur, J. W., 207 E. Main.
LE ROY.
*Skinner, Scott W., 12 Myrtle.
Skinner, S. W., Jr.
Skinner, M. H.
PAVILION.—Sweeting, S. C.
SOUTH BYRON.—Whiton, Alpha M.

### GREENE COUNTY.

*No Society.*

CATSKILL.
Goodrich, F. W., cor. Main and William.
*Vincent, Stanley, 371½ Main.
COXSACKIE.—Klaer, Clarence.
MEDWAY.—Collins, D. E.

### HAMILTON COUNTY.

(No Homœopathist.)

### HERKIMER COUNTY.

(‡*Oneida County Society.*)

HERKIMER.—‡Kern, E. G.
LITTLE FALLS.—*‡Brainard, L. L.
MOHAWK.—Landt, Wm.
SALISBURY CENTER.
Wood, E. Hamlin.
WEST WINFIELD.—Spencer, H. J.

## JEFFERSON COUNTY.

*Annual Meeting, Watertown, third Wednesday in November. President, J. E. Ryan; Vice-President, G. A. Gifford; Secretary and Treasurer, R. F. Gates.*

ADAMS.—*‡Nickelson, W. H.
ALEXANDRIA BAY.
Campbell, E. E.
Cole, J. D.
ANTWERP.—Flint, R. J.
BROWNVILLE.—‡Gates, R. F.
CAPE VINCENT.—Bushnell, H. N.
CARTHAGE.—‡Simonds, C. A.
*‡Simonds, E. A.
MANNSVILLE.—‡Hibbard, G. C.
PHILADELPHIA.—Ryan, M. M.
REDWOOD.—‡Ryan, J. E.
THERESA.—*‡Santway, F. L.
Dresser, E. Dell.
WATERTOWN.—Adams, M. M.
‡Bartlett, Geo W.
Chattaway, A. D.
Flint, Chas. B.
‡Gifford, G. A.
Smith, G. W. B.
‡Farmer, G. S.

## KINGS COUNTY.

*Annual Meeting, 44 Court St., Brooklyn, second Tuesday in January. President, W. S. Rink; Vice-President, W. J. Shrewsbury; Secretary, R. I. Lloyd; Treasurer, Herbert C. Allen; Necrologist, John L. Moffat.*

NEW YORK, BROOKLYN BOROUGH.

*‡Allen, Emma T. P., 310 Clermont Ave
*‡Allen, Herbert C., 304 Clermont Ave.
‡Aten, Wm. H., 100 Greene Ave.
*‡Avery, E. W., 16 Hancock.
‡Ayres, Rebecca J., 806 Green Ave.
*‡Baker, Jennie v. H., 512 Bedford Ave.
Barden, Wm. W., 88 Second Pl.
Barnes, Roxana K., 161 Garfield Pl.
Barnum, Fred'k L., 798 Bedford Ave.
Bartlett, G. W., Benson Ave., near Bay 22d.
*‡Baylies, B. L'B., 418 Putnam Ave.
‡Bedford, E. R., 437 Putnam.
Belden, Chas. K., 379 Gates.
*‡Bennet, G. H. R., 21 S. Portland Ave.
*‡Bierbauer, B. W., 47 Pierrepont.
*‡Birdsall, Edgar, 1038 Bedford.
‡Bishop, Gertrude G., 475 Madison.
Blackman, Mrs. Lora, 519 Clinton Ave.
*‡Blackman, W. W., 519 Clinton Av.
*‡Bolan, L. W., 413a Quincy.
Boocock, Robert, 2905 Ave. C.
‡Bornmann, Alfred, 271 Putnam Ave.
Bowman, Alice, 7 W. 101st.
‡Breck, William B., 235 Garfield Pl.
‡Brinkerhoff, A. S., 544 Monroe.
‡Broughton, L. D., Jr., 418 Madison.
Brown, Annie M., 155 Halsey.
‡Brown, Charles A., 155 Halsey.
Brownell, DeEtte, Classon and St. Mark's Ave.
*‡Bryant, W. C., 66 Greene Ave.
*Bulmer, Geo. W., 1210 Bushwick Ave.
‡Burnette, Katherine D., 486 Bedford Ave.
*‡Burnham, Clark, 182 Clinton.
*‡Butler, W. M., 507 Clinton Ave.
‡Buys, Thos. A., 707 St. John's Pl.
‡Caldwell, Frank E., 119 Henry.
‡Cameron, Elizabeth W. M., Hotel St. George.
Campbell, Alice B., 552 McDonough.
Campbell, Jno. B., 552 McDonough.
‡Cardozo, Jacob L., 223a Monroe.
Carleton, Spencer, 60 W. 49th.
Carr, H. L., 856 Lafayette Ave.
*‡Cassidy, Georgia A., 1815 Beverly Road.
†*Chamberlin, W. T., 305 Sixth Ave.
*‡Chapin, Edward, 21 Schermerhorn.
‡Chaplain, F. T., 324 Sumner Ave.
‡Clark, G. F., 515 Decatur.
‡Clarke, M. Elizabeth, 8 Lafayette Ave.
‡Close, Stuart, 209 Hancock.
‡Coddington, Fannie R., 16 Ormond Place.
‡Cornell, Geo. B., 137 Seventh Ave.
‡Cort, Lottie A., 89 Division Ave.
Crane, Chas. F., 483 E. Seventh.
*‡Denison, R. N., 55 Eighth Ave.
Dewey, Geo. A., 519 Halsey.
‡Devol, Edmond M., 127 Milton.
Deyo, J. T., 362 Ninth.
*‡Dickie, Perry, 17 Schermerhorn.
‡Diehl, W., Jr., 150 Cornelia.
*‡Durrin, Wm. C., 1038 Bedford Ave.
Dunlevy, Mrs. S. E., 166 DeKalb Ave.
Durkee, Jeannette R., 197 Harrison.
Eden, Samuel, 1340 Bushwick Ave.
*‡Elliot, Amos H., 480 Monroe.
Eltinge, R. L., Washington Ave. and St. John.
Ermentraut, Henry, 232 Hewes.
Ermentraut, J. P., 134 Hendrix.
‡Fleckles, Mary Fish, 530 Lafayette.
‡Fincke, Bernhard, 122 Livingston.



*‡Fiske, E. R., 1140 Dean.
*‡Fiske, W. M. L., 1140 Dean.
Fobes, Jos. H., Flower Hospital.
*‡Freeman, Wm. H., 297 Logan.
‡Gerrie, James, 357 Halsey.
*‡Given, James B., 463 Ninth.
*‡Gorton, D. A., Montague.
‡Hadley, C. H., 55th, near New Utrecht Ave.
‡Hale, Harriet W., 160 Decatur.
Hanford, Marie, 178 S. Fifth.
Hanford, Wm. H., 84 Lee Ave.
*‡Hasbrouck, Everitt, 389 Fourth.
‡Hayward, Abner, 426 Franklin Ave.
‡Hobby, Ada T., 397a Lafayette Av.
‡Hopke, F. Edward, 240 Emerson Pl.
‡Hopper, M. T., 46 S. Oxford.
‡Houghton, B. L., 616 St. Mark's Ave.
*‡Iler, G. H., 243 McDonough.
*‡Jeffery, G. C., 343 Jefferson Ave.
Jenks, Edwin B., Flower Hospital.
*‡Johnston, C. L., 467 Vanderbilt Ave.
*‡Kastendieck, J. T. W., 120 Hooper.
Keep, J. Lester, 460 Clinton Ave.
Klink, Sophie G., 119 Macon.
‡Knapp, H. J., 287 South Fifth.
Knott, Harriet A., 1453 Pacific.
Lassen, Helene S., 152 Henry.
‡Latimer, W. C., 351a Clinton.
*‡Lauer, Chas. F., 241 Emerson Pl.
*‡Lawrence, J. B., 289 Ninth.
*‡Lazarus, Geo. F., 10 Caton Ave.
Leverson, M. A., 81 Lafayette Ave.
‡Lines, Mary L., 285 Washington Ave.
*‡Lloyd, R. I., 450 Ninth.
‡Love, Wm. L., 1188 Dean.
‡Lowe, Evelyn, 397a Lafayette Ave.
*‡Lutze, F. H., 212 Keap.
Martino, R. R., 792 Madison.
McCune, Olive F., 53 Orange.
‡McLenathan, W. H., 101 Division Ave.
Mead, Byron E., 443 Pacific.
‡Minshull, Frances E., 130 Halsey.
*‡Minton, Henry B., 165 Joralemon.
*‡Moffat, John L., 1136 Dean.
‡Monmonier, J. L., 480 Classon Ave.
‡Moon, W. W., 488 Nostrand Ave.
Muller, Jos. H., Flower Hospital.
*‡Muncie, E. H., 119 Macon.
*‡Muncie, Mrs. L. H., 119 Macon.
‡Nichols, George, 306 Monroe.
*‡Nottage, Rachel, 669 Macon.
*‡Ogden, G. S., 641 E. 28th.
‡Onderdonk, Emma, 104 South Elliott Place.
‡Pallister, Stanley W., 376 Madison.
‡Palmer, A. J., 90 Hancock.
‡Palmer, G. H., 92 Hancock.
Palmer, Warren B., 360 Hancock.
Patton, James H., 179 Duffield.
*Peckham, Hattie C. Van Buren, 163 Halsey.
‡Pearse, Richard E., 322 Van Sicklen Ave.
Perveil, A. C., 14 Hancock.
*‡Pierron, H. J., 438 Greene Ave.
‡Pierson, W. B., 162 Macon.
‡Pierson, W. H., 101 McDonough.
‡Potter, Mary E., 297 DeKalb Ave.
*‡Preston, H. G., 54 Greene Ave.
Rankine, Isabella M., 43 Lee Ave.
‡Richards, Mary E., 213 Keap
‡Richardson, B. M., 151 Milton.
‡Richter, H. W., 620 Carlton Ave.
Reigelman, von Mrs. Laura M. Long, 43 Lee Ave.
*‡Rink, Walter S., 168 McDonough.
‡Risley, Frank E., 355 Jefferson Ave.
*‡Ritch, A. M., 711 Putnam Ave.
*‡Ritch, Orando S., 337a Macon.
*‡Robinson, Nathaniel, 89 Halsey.
Robinson, W. B., 261 Crescent.
*‡Rockefeller, H. O., 152 Jerome.
‡Rose, H. W., 1238 Bushwick Ave.
*Russell, J. E., 1032 Bedford Ave.
*‡Schall, J. H., 141 St. Mark's Ave.
*‡Schenck, H. D., 241 McDonough.
‡Schlegel, Louise, 472 Willoughby Ave.
*‡Searle, W. S., 62 Clark.
‡Seeley, W. W., 44 Hanson Pl.
‡Shrewsbury, W. J., 238 Keap.
*‡Simmons, D., 1188 Dean.
‡Simon, S. H., 195 Garfield Pl.
‡Sisson, Mabel C., 519 Greene Ave.
‡Slee, H. C., 277 Hewes.
‡Smith, Clara Louise, 124 Prospect Pk.
*‡Smith, G. H., 921 Greene Ave.
*‡Smith, Geo. H., Jr., 758 Greene Ave.
‡Smith, Sidney E., 78 Arlington Ave.
Spooner, E. H., 579 Macon.
‡Stafford, Fred E., 142a Putnam Ave.
*‡Stewart, J. A., 1030 Bedford Ave.
‡Stolz, Rosalie H., 778 Putnam Ave.
Straley, May W., 282 Halsey.
*‡Street, H. E., 98 Brooklyn Ave.
‡Sutton, John J., 120 Vernon Ave.
*‡Talmage, Samuel, 22 Schermerhorn.
‡Terwilliger, W. C., 595 Hancock.
‡Thompson, J. M., 386 Clinton.
‡Turton, M. Louise, 360 Greene Ave.
‡Van Arnam, Mrs. A. B., 136 Monroe.
Van Kleek, J. H., 707 Union.
‡Van Mater, G. G., 354 Macon.

*‡Van Schoonhoven, C. S., 1060 Lafayette Ave.
‡Von der Lühe, Amelia D. F., 801 Driggs Ave
*‡Von der Lühe, Augustus, 245 Hooper.
Walters, Chas. A., 111 Milton.
‡Walmsley, R. F., 491 Putnam.
*‡Warner, Alton G., 19 Schermerhorn.
*‡Wemmel, A. A., (Ecl. Lic.), 2600 Atlantic Ave.
*‡Wiggins, T. C., 12 Verona Pl.
‡Williams, F. B., 583 Bedford Ave.
Willis, Clinton, 494 Putnam Ave.
*‡Willis, H., 569 Monroe.
*‡Winchell, W. B., 137 Berkeley Pl.
Wood, Fiske, 101 Division Ave.
Woolley, Charlotte H., 676 Prospect Pl.
*‡Wright, Justus G., 363 Eleventh.
WOODHAVEN.—(Long Island.)
‡Casselberry, J. L.

## LEWIS COUNTY.

(*‡Jefferson County Society.*)

COPENHAGEN.—*Hall, C. B.
LOWVILLE.—‡Bronson, Miles H.

## LIVINGSTON COUNTY.

*No Society.*

AVON.—Allen, Cyrus.
CALEDONIA.—*Borden, G. T.
Cole, D. D.
DANSVILLE.
*Andrews, B. P., 103 Main.
GENESEO.—*Page, Roy A.
Southall, E. W.
LIMA.—*Mackenzie, John A.
LIVONIA.—Bettis, J. T.
LIVONIA STATION.
Trimmer, W. S.
MOUNT MORRIS.—Leach, A. E.
NUNDA.—*Ostrander, P. M.
SPRINGWATER.
Knickenbocker, Herbert D.

## MADISON COUNTY.

*Annual Meeting, Oneida, fourth Tuesday in June. President, B. R. Gifford; Vice-President, E. N. Coon; Secretary and Treasurer, J. T. Wallace.*

CANASTOTA.—Deuel, W. E.
CAZENOVIA.—‡Bass, E. C.
CHITTENANGO.—*‡Deuel, W. E.
DE RUYTER.—‡Coon, E. N.
EAST HAMILTON.—‡Palmer, G. B
HAMILTON.—*‡Gifford, G. L.
*‡Willcox, G. W.
MADISON.—‡Gifford, Barton R.
NORTH BROOKFIELD.
York, G. T.
ONEIDA.—‡Wallace, J. T.

## MONROE COUNTY.

*Annual Meeting, Rochester Homœopathic Hospital, third Tuesday in January. President, W. H. Doane; Vice-President, Wm. S. Rambo; Secretary, L. J. Sanders; Treasurer, H. A. Anderson.*

BRIGHTON.—Wheeler, J. P.
BROCKPORT.—Winne, F. A.
EAST HAMLIN.—Darrow, S. W.
FAIRPORT.—*‡Clapp, W. F.
‡Price, George S.
HONEOYE FALLS.—Brown, D. G.
*‡Otis, Chas. F.
*White, Benj. R.
PENFIELD.—Humphrey, N. M.
PITTSFORD.—*‡Doane, W. H.
ROCHESTER.
*‡Adams, Myron H., 821 Granite Building.
*‡Adams, R. A., 46 N. Fitzhugh.
‡Anderson, H. A., 391 West Ave.
*‡Bachman, G. A., 167 South Ave.
Biegler, J. A., 58 Clinton Ave. S.
*‡Bissell, E. J., 75 South Fitzhugh.
Brownell, J. R., 224 Alexander.
Brownell, W. G., 122 North.
*‡Buell, Jesse W., 41 Clinton Ave. S.
Bunnell, L. M., Jr., Hahnemann Hospital.
‡Button, L. L., 265 Alexander.
†‡Carman, W. B., 23 Upton Park.
Chaffee, D. J., 8 Clinton Ave.
†‡Chamberlayne, Mrs. Louise F., 16 State.
*‡Clapp, C. R., 427 Hayward Ave.
*‡Collins, N. M., 43 East Ave.
Curtiss, W. H., 36 Clinton.
Dake, W. E., 271 Monroe Ave.
Daley, W. C., 7 Argyle.
Dixon, W. Walker.
Earle, E. W., 55 Monroe Ave.
*‡Fowler, W. P., 63 Clinton Ave. S.
Fritz, A. R., 28 Draper.
*‡Graham, M. E., 700 South Ave.
Grant, R. C., 279 South Ave.
*‡Haywood, G. M., 48 Clinton Ave. S.
*‡Haywood, Julia F., 612 West Ave.
Hermance, A. C., 611 St. Paul.
Hermance, S. G., 568 Plymouth Ave.
Hoard, V. A., 637 Main, East.
*‡Hoyt, Herbert W., 75 S. Fitzhugh.



‡Hoyt, Mrs. Mary M., 10 Westminster Road.
Johnson, W. W., 20 Triangle Bldg.
*‡Keegan, W. A., 40 Clinton Ave. S.
*‡Kellogg, C. M., 42 Clinton Ave. N.
*‡Lee, J. M., 179 Lake Ave.
*MacCallum, John H., 408 Monroe Ave.
McCullough, Alice S., 19 Laburnam.
Morton, Pauline, 27 Clinton Ave. S.
*‡Neefus, P. W., 124 East Ave.
Norman, A. J., 186 Alexander.
*‡Parsons, Thomas, 213 Alexander.
Perrine, C. W., 76 Clifton.
*Phillips, R. F., 21 Park Ave.
Proctor, J. C., 29 Buckingham.
*‡Rambo, W. S., 41 Sophia.
*‡Ricker, Mrs. M. S., 58 Lorimer.
Ross, E. V., 279 Jefferson Ave.
*‡Sanders, L. J., 421 Monroe Ave.
Sayles, Emma S., 13 Park Ave.
Schnell, A. E.
‡Shepard, H. G., 517 Monroe Ave.
*‡Smith, F. R., 89 Plymouth Ave.
*‡Snow, S. R., 267 Alexander.
*‡Spencer, T. D., 24 S. Union.
‡Stillwell, F. W., 32 University Ave.
*‡Sumner, C. R., 33 Clinton Ave. S.
Thomson, G. M., 246 East Ave.
*‡Thurber, T. J., 157 Plymouth Ave.
‡Tretton, J. K., 239 Lake Ave.
‡Van Allan, R. A., 234 Monroe Ave.
Wadsworth, Robert, 176 State.
Willis, F. L. H., 243 Alexander.
†Winans, W. W., 33 Clinton Ave. S.
*‡Wolcott, E. H., 57 South Union.
SCOTTSVILLE.—Archer, D. E.
SOUTH GREECE.
*‡Buell, E. S., (Lic.)
WEBSTER.—†‡Whittleton, E. J.

## MONTGOMERY COUNTY.

*Annual Meeting at Fonda, second Wednesday. Quarterly Meetings. President, H. M. Hicks; Vice-President, F. L. Towne.*

AMSTERDAM.
*‡Frazier, L. A., 124 Division.
‡Hicks, H. M.
‡White, Wm. M., 26 Pearl.
FONDA.—Foster, A. B.
FORT PLAIN.—‡Zoller, Wm.

## NASSAU COUNTY.

*No Society.*

GLEN COVE.
*Ginnever, Arthur, Glen.
HEMPSTEAD.
Lount, Robert, 79 Fulton.
GLEN HEAD.—Freeman, Geo. L.

## NEW YORK COUNTY.

(MANHATTAN AND BRONX BOROUGHS.)

*Annual Meeting, second Thursday in December, at Carnegie Hall, President, F. H. Boynton; Vice-President, Irving Townsend; Secretary, J. Perry Seward; Treasurer, C. S. Macy; Librarian, Chas. Ver Nooy.*

*‡Allan, Arthur G., 14 W. 32d.
‡Allen, J. Wilford, 110 W. 12th.
*‡Allen, Paul, 3 E. 48th.
*‡Allen, T. F., 3 E. 48.
*‡Ambler, J. Edgar, 134 E. 19th.
‡Andrew, R. M., 1730 Washington.
Arcularius, P. E., 104 W. 44th.
‡Arschagouni, John, 727 Lexington Ave.
Atkins, L. R., 108 W. 96th.
*Austin, A. E., 17 E. 66th.
Badaurs, Ida, 222 E. Broadway.
‡Bagg, C. L., 26 W. 46th.
Baker, C. M., 43 Sixth Ave.
‡Baker, C. R., 144 Convent Ave.
Baker, Dan'l J., Blackwell's Island.
*‡Baldwin, J. G., 8 East 41st.
Baldwin, Mary H., 274 Third Ave.
Barker, Caleb, Park Ave. and 67th.
Baruch, Emanuel, 57 E. 77th.
Bassett, J. S., 11 West 31st.
‡Beals, M. B., 97 E. 116th.
Beckwith, S. A., Metropolitan Hospital.
Beers, M. I., Blackwell's Island.
‡Bennett, J. A., 4 Irving Pl.
Bergeson, Emma C., 251 W. 132d.
*‡Berghaus, A., 138 East 65th.
*‡Beyea, J. L., 217 Second Ave.
‡Bickford, Lydia A., 12 W. 39th.
Biegeleisen, Nathan, 287 3rd Ave.
‡Bigelow, A. J., 163 E. 106th.
Bingham, A. H., 113 W. 87th.
*‡Bishop, Wm. H., 56 W. 48th.
Bissell, Sarah E., 207 W. 14th.
Black, Caroline L., 114 W. 123d.
Blakeman, J. L., 1977 Seventh Ave.
*‡Bond, Mary E., 122 Lexington Ave.
*Bonnewitz, Orlando R., 143 W. 122d.
*‡Boyle, G. C., 49 W. 37th.
*‡Boynton, F. H., 36 West 50th.
‡Bren, M. R., 1949 Seventh Ave.
Broeser, Henry E., 63rd and Eastern Boulevard.
Brown, F. H., Metropolitan Hosp.
‡Brown, G. C., 56 West 45th.
*‡Brown, M. Belle, 30 W. 51st.
Bryson, Louise F., 66 West 53d.
*‡Buchanan, T. D., 328 W. 24th.
*‡Buchholz, Louise Z., 73 St. Mark's.
Burd, Emma deL., 456 Manhattan.
Burdick, Mrs. Alice H., 339 W. 34th.

Campbell, Annie S., Jerome Ave. and 163d.
‡Campbell, C. E., 314 East 18th.
‡Cannon, M. D., 131 W. 122d.
*‡Carleton, B. G., 75 W. 50th.
‡Carleton, E., 62 W. 49th.
Carleton, Spencer, 62 W. 49th.
Carpenter, Fred. A., 341 W. 23d.
Chamberlin, G. M., 26 West 129th.
Chambers, M. G., Metropolitan Hospital.
‡Chapman, A. E., 115 W. 44th.
*Charles, Emily C., 51 W. 127th.
*‡Chase, J. O., 214 East 53d.
Church, Charles A., 41 W. 26th.
Clark, B. B., 171 W. 126th.
*‡Clark, B. G., 25 N. 74th.
Clemons, Carl, 78 Irving.
Clock, Sarah A., 325 Amsterdam Ave.
Cochrane, G. D., 48 W. 57th.
Coghlan, J. W., Metropolitan Hospital.
Coleman, C. E. S., Metropolitan Hospital.
Conklin, Chas. E., 161 E. 62d.
Cooke, Mrs. H. N. F., 1145 Park Ave.
Cornell, V. A. H., Metropolitan Hospital.
Cornwell, F. W., Metropolitan Hospital.
‡Cossart, A. B., 1378 Lexington Ave.
Crompton, Chas. W., 1884 Boston Ave.
*‡Crump, W. G., 693 Madison Ave.
Currie, S. E., 366 W. 55th.
*‡Danforth, L. L., 49 W. 52d.
Daniels, J. L., 51 W. 127th.
*Davies, Thos. F., 359 W. 116th.
Davis, Jane C., 239 E. 49th.
*‡Davis, J. E. L., 743 Madison Ave.
*‡Deady, Chas., 151 W. 73d.
Dearborn, Fred. M., 146 W. 57th.
*‡Dearborn, H. M., 146 W. 57th.
Decker, J. W., 8 W. 45th.
*‡Delabarre, W. E., 224 Central Pk.
*‡Demarest, J. H., 59 W. 126th.
*Dieffenbach, W. H., 1748 Broadway
*‡Dillingham, T. M., 8 W. 49th.
*‡Dillow, George M., 223 W. 57th.
‡Donoghue, Anna F., 400 W. 57th.
*‡Doughty, F. E., 512 Madison Ave.
*‡Dowe, F. Le C., S. Boulevard and Briggs Ave.
*‡Dowling, J. W., 116 W. 48th.
‡Dryer, F. H., 747 E. 176th.
‡Dunlevy, Rita, 328 W. 57th.
‡Durrie, G. B., 103 W. 54th.
Eden, J. H., 14 E. 42nd.
Edmonstone, Elizabeth, 40 W. 25th.
‡Edwards, Mary L., 19 W. 46th.
*‡Eife, Arthur F., 175 W. 10th.
Eife, Francis, 335 E. 18th.
Elebash, Clarence S., 118 E. 19th.
Elmendorf, T. C., 344 E. 42d.
Embley, F. W., 314 E. 18th.
‡Emery, Mary E., 107 W. 82d.
‡Ermentraut, J. P., 44 Seventh.
Evans, C. V. S., 255 W. 122nd.
*‡Ferrier, Jas. M., 166 E. 111th.
Finch, Joseph, 106 W. 44th.
Fleming, W. L., 174 St. Nicholas.
Fletcher, Addison C., 332 W. 19th.
Foster, Mary E., 413 W. 46th.
*‡Fralick, W. G., 778 Madison Ave.
*‡Franklin, E. D., 325 W. 14th.
‡Gage, Mary E., 19 W. 46th.
Gardiner, D. M., Metropolitan Hospital.
Garrison, H. W., 154 E. 86th.
*‡Garrison, J. B., 111 E. 70th.
George, F. S., Metropolitan Hosp.
*Gennerich, Chas., 181 E. 64th.
Gilbert, C. E., 323 W. 23d.
Gillespie, L. S., 264 Monroe.
Gillette, Eliz., 1381 Boston Rd.
‡Gillingham, H. P., 223 E. 86th.
‡Goodrich, S. W., 507 W. 152d.
*Gore, Jennie E., 1145 Park Ave.
Gray, R. B., 202 W. 81st.
Graffin, J. C., Hahnemann Hosp.
‡Graham, N. C., 261 W. 34th.
*‡Guernsey, Egbert, 180 South Central Pk.
‡Hall, James W., 335 W. 56th.
*‡Hallett, G. D., 132 W. 81st.
Hallock, Frank M., 134 W. 65th.
*‡Hamlin, F. W., 130 W. 48th.
Hardy, O. S., 912 West End Ave.
‡Harrington, Gove S., 487 W. 145th.
Harris, James E., 2000 Lexington.
*Harris, James W., 229 E. 124th.
‡Hart, A. H., 130 W. 44th.
*‡Hartley, W. G., 335 W. 24th.
Hartz, S. Emma, 102 W. 44th.
Hasbrouck, Stephen, 20 Nassau.
Haskins, Cordelia C., 57 W. 84th.
*‡Hathaway, H. S., 146 W. 92d.
*‡Heltfrich, C. H., 542 Fifth Ave.
*‡Helmuth, W. T., 26 E. 62nd.
*Hill, Emily L., 250 W. 94th.
Hills, A. T., 309 Broadway.
Hills, A. K., 669 Fifth.
‡Hinkley, Abbie G., 242 W. 52d.
‡Hollister, F. K., 59 E. 52nd.
*‡Honan, W. F., Broadway and 71st.
‡Howard, C. C., 57 W. 51st.
*‡Howe, J. M., 12 W. 46th.
‡Hoyt, F., 39 W. 58th.
House, W. B., 203 E. 116th.
*Hrdlicka Ales, 106 E. 71st.
Huff, E. N., Metropolitan Hosp.



Hughes, D. Jane, 229 W. 42d.
‡Hull, G. A., 123 W. 73d.
*‡Hunt, D. B., 150 Madison Ave.
*‡Hutchinson, John, 78 E. 55th.
Husson, John, 280 St. Nicholas Av.
Hughes, Harriet, 148 W. 85th.
Irish, James H. E., 63rd & Ave. A.
Jackson, G. G., Blackwell's Island.
‡Jardin, Roland du, 129 E. 76th.
‡Jarrett, Elizabeth, 1 W. 101st.
Johnson, P. R., 110 W. 79th.
Jones, Robt. M., 130 W. 48th.
Jones, W. H., 202 W. 74th.
‡Keatinge, Mrs. H. C., 141 W. 71st.
‡Keatinge, Harriette d'E., 141 W. 71st.
‡Keep, Mrs. C. J. Y., 308 W. 36th
*‡Kellogg, E. M., (retired) 115 E. 37th.
King, Julius, 2 Maiden Lane.
Kelly, Chas. W., 473 Park Ave.
‡Kidder, Hugh, 305 W. 46th.
*‡King, W. Harvey, 64 W. 51st.
*‡Klots, E. D., 132 W. 48th.
Kolb, Henry, 356 W. 42d.
‡Krause, W. H., 329 E. 14th.
Lacina, A. M., 346 E. 72nd.
*‡Laidlaw, A. H., 58 W. 53d.
*‡Laidlaw, G. F., 58 W. 53rd.
*‡Land, J. F., 130 W. 126th.
Lang, Wm. P., Metropolitan Hosp.
*Lannin, Louise, 148 W. 85th.
*‡Leal, Malcolm, 107 W. 48th.
Leao, F. Garcia, 234 E. 86th.
Lerrigo, P. H. T., Flower Hosp.
Lewis, F. P., 25 E. 124th.
Lewis, Henry M., 109 E. 18th.
Lewis, N. H., 224 E. 23d.
‡Linsley, J. S., 170 Washington Ave.
Livor, J., 44 E. 31st.
Lozier, A. W., 125th and 7th Ave.
Lund, F., 265 W. 81st.
‡MacBride, N. L., 4 E. 43d.
Mack, Gertrude, 171 E. 83rd.
*‡Macy, C. S., 103 W. 71st.
*‡Maeder, J. G., 304 East 120th.
Marcy, E. E., 396 Fifth Ave.
Mayer, Henrietta, 226 E. 87th.
‡McDonald, R. E., 2063 Madison Ave.
*‡McDonald, W. O., 9 W. 68th.
*‡McDowell, Chas., 110 W. 12th.
*‡McDowell, Geo. W., 136 W. 130th and 542 Fifth Ave.
McIntosh, S. D., 222 W. 43d.
Mac Ivor, Jas. H., 716 E. 138th.
*‡McMichael, A. R., 969 Madison Ave.
*‡McMichael, D. A., 5 W. 92nd.
McMichael, J. E., 53 W. 89th.
McNight, W. C., Metropolitan Hospital.
*‡Meyer, Oscar N., 171 E. 78th.
Miller, J. D., 43 W. 12th.
Miller, C. H., 112 W. 96th.
Miller, Eli P., 324 W. 57th.
Miller, John F., 39 W. 26th.
Miller, Nancy M., 41 W. 26th.
*‡Mills, Walter S., 154 W. 119th.
‡Miner, F. C., 1134 Forest Ave.
‡Mitchell, Chas. A., 2026 7th Ave.
Mitchell, R. E., Metropolitan Hosp.
‡Mitchell, L. S., 61 W. 99th.
Moore, S. B., Metropolitan Hosp.
Morgan, G. E., 2024 Madison Ave.
‡Morgenthaler, Sophia, 129 W. 64th.
*‡Mossman, N. A., 72nd, corner Broadway.
Mount, Margaret A. B., 572 Lexington Ave.
‡Müller, C. W., 209 E. 87th.
*Muncie, E. H., 14 W. 32d.
Muncie, Libbie H., 14 W. 32d.
‡Munson, E. S., 16 W. 45th.
Myers, Chas. F., 261 W. 37th.
*‡Neilson, Howard S., 63 W. 54th.
Neumiller, M., Metropolitan Hosp.
‡Newcomb, Obadiah, 233 East 12th.
Nichols, E. J., Metropolitan Hosp.
Noble, R. E., 125 W. 21st.
*‡Norton, A. B., 16 W. 45th.
Norton, D. O., Metropolitan Hosp.
*‡Nott, F. J., 554 Madison Ave.
‡Nutter, Mary E., 144 Lexington Ave.
Nye, F. A., 2091 Lexington Ave.
‡O'Brien, Evelina C. D., 226 E. 87th.
‡O'Connor, Mrs. H. M. C., 7 W. 42d.
*‡O'Connor, J. T., 7 W. 42d.
Ogden, Edwin C., 10 E. 32d.
Ohley, C. H., 153 E. 34th.
*‡Ostrom, H. I., 42 W. 48th.
*‡Paige, H. W., 256 W. 57th.
*‡Palmer, A. W., 210 W. 57th.
Palmer, Helen C., 5 W. 82nd.
‡Palmer, John B., 21 E. 24th.
‡Palmer, Miles W., 235 E. 18th.
‡Pardee, E. B., 218 W. 34th.
Pardee, Walter, 218 W. 34th.
‡Patchen, G. H., 20 W. 59th.
*‡Pearsall, W. S., 128 W. 78th.
Pelham, M. A., 108 W. 120th.
Perkins, C. W., Metropolitan Hosp.
*‡Pettet, Isabella M., 308 E. 15th.
*‡Pierce, W. Ide, 64 W. 126th.
Piersons, A. M., 24 E. 127th.
Phillips, W. H., Blackwell's Island.
Poindexter, H. M., 1145 Madison Ave.
*‡Porter, E. H., 181 W. 73d.
*‡Powel, Milton, 163 W. 76th.
*Powelson, Arthur P., 102 Convent Ave.
*‡Queen, L. A., 261 W. 72nd.

*‡Rabe, F. E., 227 W. 42d.
*‡Rankin, E. G., 226 W. 59th.
‡Rannefeld, A. H., 85 Seventh.
Raynor, Geo. F., 989 E. 169th.
Read, A. S., 157 W. 51st.
Read, W. A., 46 W. 83d.
*‡Reynolds, W. U., 320 Manhattan Ave.
Ricardo, J. N., 223 W. 135th.
*‡Richardson, A. J., 39 E. 83d.
*Richardson, G. W., 138 E. 79th.
Riordan, P. D., 456 Lexington Av.
*‡Ritchie, F. G., 131 W. 47th.
Roberts, Eugene P., 252 W. 53d.
*‡Roberts, G. W., 170 Central Pk.
Rounds, Irene S., 110 W. 49th.
*‡Rounds, W. E., 110 W. 49th.
Royle, Sinclair K., 101 W. 84th.
*‡Rudderow, E. D., 145 W. 88th.
*‡Russell, H. E., 30 E. 74th.
Scheel, Sophia B., 970 Park Ave.
*‡Schley, J. Montfort, 628 Fifth.
Schofield, J. D., Metropolitan Hosp.
*‡Scott, W. H., 104 W. 44th.
*‡Sewall, S. G., 71 E. 12th.
‡Seward, J. Perry, 200 W. 70th.
‡Sheldon, F. P., 223 W. 122d.
Sheldon, B. B., Flower Hospital.
*‡Shelton, G. G., 521 Madison Ave.
*‡Shepard, G. A., Broadway and 52d.
Sherman, Emma, 20 W. 104th.
*‡Sherman, Irving P., 59 W. 90th.
‡Sherman, L. B., 355 W. 14th.
‡Simmons, R. S., 129 E. 59th.
*‡Simonson, J. T., 46 W. 85th.
*‡Simpson, E. D., 320 W. 115th.
Sinsabaugh, J. A., 672 Second Ave.
Slay, J. Clark, 503 Fifth Ave.
Smith, G. B., 35 E. 28th.
Smith, Max. M., 221 E. 81st.
Smith, Nelson, Jr., 151 W. 48th.
‡Smith, Roswell D., 2676 Creston Ave.
*‡Smith, St. Clair, 25 W. 50th.
*‡Smith, T. F., 264 Lenox Ave.
‡Smyth, S. H., 223 E. 19th.
*‡Stanton, L. M., 132 W. 58th.
*‡Stevens, Anna C. R., 247 W. 42d.
*Stevens, D. D., 49 W. 83rd.
‡Stewart, G. T., Bellevue Hospital.
Stewart, Ralph A., 63rd and Eastern Boulevard.
*Stiles, Henry R., 113 William.
*‡Storer, J. H., 30 Edgecombe Ave.
Strader, C. A., Metropolitan Hosp.
*Swift, E. P., 170 W. 88th.
Tantum, P. L., 239 West 21st.
‡Tappen, Ella C. Jones, 346 W. 123d.
*‡Teets, C. E., 56 W. 39th.
Terry, J. Antonia, 73 W. 89th.
Thompson, A. F., Blackwell's Isl'd.
Thompson, J. C., Jr., 1373 Washington.
‡Thompson, J. H., 36 E. 30th.
*‡Thompson, Virgil, 56 W. 21st.
‡Thomson, J. W., 159 W. 48th.
Tinker, Chas. A., 124 W. 121st.
Tinker, H. H., 1257 Washington Ave.
Todd, C. M., Metropolitan Hosp.
*‡Townsend, Chas. W., 152 W. 48th.
*‡Townsend, Irving, 67 W. 46th.
‡Townsend, Katherine G., 354 W. 123d.
Townsend, Richard, 125 W. 58th.
*‡Tuttle, E. G., 61 W. 51st.
*‡Tytler, G. E., 113 W. 126th.
*‡Van den Berg, Wm. H., 32 W. 49th.
Van Landt, 107 E. 62d.
*‡Vehslage, S. H., 117 W. 43d.
‡Ver Nooy, Chas., 146 W. 64th.
‡Vondergoltz, Eric, 182 Second Av.
*‡Wait, Phebe J. B., 9th Av. and 34th
*Waite, Anne L. Langworthy, 1381 Boston Ave.
Walker, B. D., 162 E. 122nd.
Walker, L. E., 155 Worth.
Wallin, A. C., 460 W. 145th.
Walter, Josephine, 61 W. 74th.
Webster, A. B., Metropolitan Hosp.
Weatherby, J. K., Metropolitan Hospital.
‡West, Edwin, 155 W. 12th.
*‡Wetmore, J. McE., 43 W. 54th.
*‡White, A. Lenora, 151 W. 46th.
White, Sarah C. L., 129 E. 81st.
‡White, W. Storm, 58 W. 48th.
‡Whitehorne, F. N., 64 W. 126th.
Whiteman, J. L., 156 W. 45th.
‡Whittemore, Margaret, 32 W. 24th.
Whitemyre, J. P., 63rd and Ave. A.
Wilcox, Emma D., 20 W. 104th.
*‡Wilcox, Sidney F., 51 W. 52d.
‡Wilder, L. de V., 55 W. 33d.
Wildes, Thos., 610 Lexington Ave.
Williams, Cordelia, 129 W. 64th.
*‡Williams, T. C., 118 E. 19th.
‡Winterburn, G. W., 46 Bradhurst.
‡Wood, J. Robie, 31 W. 19th.
‡Woodward, A. M., 128 W. 113th.
‡Worrall, M. Ruth, 1456 Lexington Ave.
Wright, P. W., 126 W. 104th.
‡Young, Chas. H., 160 W. 48th.
*‡Zeckhausen, Harry, 315 E. 4th.

## NIAGARA COUNTY.

*No Society.*

GASPORT.—Knapp, F. L. (retired).
LOCKPORT.
*Blackley, Carl, 247 Washburn.
Buck, Champlin F., 49 Main.
*Hurd, S. W., 78 Main.
Paxon, Charles, 78 Main.
Pettit, W. M., 32 Spaulding.
Pettit, Gaylord J., 13 East Ave.
Rice, William B.
Watters, Fowler A., 29 Main.
MIDDLEPORT.
Robertson, Mrs. Helen M.
NIAGARA FALLS.
Gray, John, 1712 Main.
Hodge, John W., 10 Gluck Block.
*Hodge, Wm. H., 8 Gluck Block.
*Hough, Walter D., 635 Main.
NORTH TONAWANDA.
Bentley, F. W.
WILSON.—Draper, Wm. L.

## ONEIDA COUNTY.

*No Society.*

CLAYVILLE.—Dewing, W. H.
BOONVILLE.—Babcock, E. C.
CLINTON.—‡Dever, I.
ROME.—‡Gifford, Alden.
*‡Southwick, A. B.
*‡Scudder, N. C.
TRENTON.—‡Spencer, R. S.
UTICA.
*Alliaume, C. E., 219 Genesee.
Bruce, A. H., 30-31 Gardner Bldg.
*‡Capron, C. G., 219 Genesee.
*‡Chase, C. E., 5 Winston Bldg.
*Dean, L. W., 40-41 Cardner Bldg.
Fairbank, Stuart J., 9 West.
Gayde, E. A., 189 Lansing.
‡Guile, E. B., 13-14 Winston Bldg.
*Grant, A. R., 366 Genesee.
*Haines, Charles T., 42-43 Cardner Building.
‡Hennessy, Margaret E., 15 Winston Bldg.
*‡Terry, M. O., 196 Genesee.
*‡Watson, W. H., 270 Genesee.
WATERVILLE.
*Randall, Edward G.

## ONONDAGA COUNTY.

*Annual Meeting, Syracuse, first Tuesday in May. President, W. C. DuBois; Vice-President, C. E. Hinman; Secretary and Treasurer, A. G. Anthony.*

BALDWINSVILLE.—Burch, J. H.
Heaton, Ely.
‡Martin, Alden.
‡Martin, Leslie.
ELBRIDGE.
Kaple, Edward B.
‡Warren, Erastus.
FAYETTEVILLE.—Badgly, C.
Hutchinson, P.
JORDAN.—‡Warren, S. C.
Spire, C. E.
LYSANDER.—Doud, F. H.
LAFAYETTE.—‡Willer, A. M.
LIVERPOOL.—‡Young, J. R.
MARCELLUS.—Northway, W. L.
MEMPHIS.—‡Sullivan, N. B.
SKANEATELES.—*‡Cooper, C. S.
SPAFFORD.—*Barker, G. E.
SYRACUSE.
‡Anthony, A. G., 608 S. Warren.
*Baldwin, G. E., 500 University Ave.
‡Brewster, A. J., 211 Shonnard.
*‡Candee, J. W., 501 Fayette Pk.
†‡Chaffee, R. W., 1641 W. Genesee.
*Church, Herbert A., 601 Warren.
‡Crowell, L. C., 915 E. Fayette.
*‡Du Bois, Willard C., 519 S. Salina.
‡Emens, Harriet D., 321 Montgomery.
‡Flint, E. H., 1624 W. Genesee.
*‡Gridley, Geo. L., 1232 S. Salina.
Greeley, Geo. H., 510 S. Warren.
Guild, L. S. L., 329 James.
‡Hale, C. D., 311 Warren.
*‡Hartman, W. L., 737 University Ave.
‡Hinman, C. E., 114 Slocum.
‡Hooker, Frederick, 117 Kirk Block.
*‡Hoyt, Gordon W., 808 Madison.
Irons, F. L., 224 Grace.
†‡Keeler, E. E., 452 Salina.
*‡Keese, J. M., 211 Shonnard.
*‡Kinne, A. B., 410 Fayette Pk.
*‡Kinne, E. O., 516 Warren.
Leonard, H. L., 1518 S. Salina.
†‡Lukens, C. M., 207 E. Onondaga.
‡Putnam, F. B., 310 E. Fayette.
‡Schumacher, Carl, 216 Ash.
*‡Sheldon, J. W., 501 Fayette Pk.
*‡Sherwood, B. W., 1117 S. Salina.
TULLY.—‡Barker, G. E.
*Leonard, Wm. H.
WARNER'S.—‡Houston, S. W.

## ONTARIO COUNTY.

*Annual Meeting, Canandaigua, second Wednesday in October. President, J. C. Knapp; Vice-President, C. A. Rowley; Secretary and Treasurer, C. T. Mitchel.*

CANANDAIGUA.
†‡Mitchel, C. T., 2 Park Pl.
*‡Warner, F. P.
CLIFTON SPRINGS.
Boynton, John R.
Conley, L. P.
EAST BLOOMFIELD.
*‡Partridge, Barton S.
GENEVA.—*‡Covert, N. B.
*Hopkins, W. W.
*‡Knapp, James C.
‡Stebbins, J. H.
NAPLES.—Conley, D. C.
PHELPS.—‡Pritchard, G. C.
PORT GIBSON.—*Throop, A. I.

REED'S CORNERS.—Marsh, Jas. M.
SHORTSVILLE.—‡Cooke, J. D.
VICTOR.—*‡Rowley, C. A.

### ORANGE COUNTY.

*Meeting, June 24th, Newburgh.*

CORNWALL-ON-HUDSON.
Chandler, David H.
GOSHEN.—*McGeoch, R. L.
*Seward, F. W., Jr.
*Seward, F. W.
MIDDLETOWN.
*Ashley, Maurice C.
*Barrus, Clara.
Bradner, Julia A.
*Brewster, Geo. F.
*Everett, Edward A.
*Fancher, E., 16 Orchard.
Hanmer, J. La T., 6 Low Block.
Powelson, Howard J,
Schulz, E. M.
Turner, Reeve.
Wilson, Isabella.
*Woodman, R. C.
NEWBURGH.
Brink, Wm. H., Grand Ave. (retired).
*Jacobson, F. A., 269 Grand.
Mitchell, Geo. B. I., 116 Liberty.
*Mitchell, J. J., 242 Montgomery.
Snyder, W. H., 130 Third.
PORT JERVIS.—*Best, Fred'k W.
Lambert, E. B.
WALDEN.—Faulkner, W. H.
WARWICK.—Cummins, Frank M.
Cummins, J. Seeley.
WASHINGTONVILLE.
Reed, Wm. E.

### ORLEANS COUNTY.

*No Society.*

ALBION.—Norton, F. R.
CLARENDON.—Conklin, R. C.
MEDINA.—*Gillette, Myra A.
Scott, F. W.
*Swett, Emily F.

### OSWEGO COUNTY.

*Annual Meeting, Oswego, second Tuesday in June. President, W. L. Woodbury; Vice-President, N. H. Haviland; Necrologist, Secretary and Treasurer, L. B. Richards.*

FULTON.—‡Woodbury, W. L.
*‡Haviland, N. H.
MEXICO.—‡Radway, C. W.
‡Stow, T. D.
OSWEGO.
*‡Albertson, C. S., 9 W. Bridge.
‡Calisch, A. C., 55 W. Bridge.
*‡Hinman, E. L., 84 W. Oneida.
‡Richards, L. B., E. Bridge and 2d.
PHOENIX.—Young, Daniel F.

### OTSEGO COUNTY.

*No Society.*

COOPERSTOWN.—Blodgett, T. S
Harrison, H. A.
HARTWICK.—Luce, Daniel.
MORRIS.—Matison, Merritt.
ONEONTA.—*Getman, A. D.
OTEGO.—Cossart, James.
RICHFIELD SPRINGS.
Getman, Norman.
Ward, Henry A.
UNADILLA.—Clark, P. G.

### PUTNAM COUNTY.

(‡*Westchester County Society.*)

COLD SPRING.—Winslow, James M.
BREWSTER.—*‡Newman, L. G
*Brinkman, Mrs. M. A.
PATTERSON.—*Birdsall, Thomas P.

### QUEENS COUNTY.

(‡*Kings County Society.*)

NEW YORK, FLUSHING.
Allen, Wm. A., Bowne Ave.
Fox, John J.
*Foster, Wm. E., 126 Madison Ave.
Gill, J. W.
NEW YORK, JAMAICA.
Belden, Chas. K., 28 Clinton Ave
*‡MacFarland, R. L., 53 Clinton Ave.
Noble, Herbert. 49 Union Ave.
NEW YORK, LONG ISLAND CITY.
Brennan, F. E.
Finerty, J. W., 134 Third.
Platt, C. N., 152 Franklin (Astoria).
Strong, C. E., 152 Franklin (Astoria).

### RENSSELAER COUNTY.

(‡*Albany County Society.*)

CASTLETON.—Welch, C. D.
EAGLE BRIDGE.—Rider, E. H.
EAST GREENBUSH.—Curran, S. C.
GREENBUSH.
Miller, Horace C., 78 Broadway.
HOOSICK.—Donnelly, James H.
HOOSICK FALLS.—Hudson, F. R
Lamb, G. M.
Putnam, W. B.
*Shaw, J. C.
LANSINGBURGH.
Holmes, H. P., 512 Second Ave.
TROY.
*Benson, R. F., Jr., 2 St. Paul Pl
Belding, R. E., 2141 Fifth Ave.
Bloss, Fred S., 70 Second.



Bloss, Jabez P., 108 Second.
Bloss, Richard D., 1810 Fifth Ave.
*Coburn, E. S., 91 Fourth.
Crandall, E. L., 1943 Fifth Ave.
Delavan, E. H., 1915 Fifth Ave.
*Green, A. R., 25 Second.
‡Griffin, Jennie, Pawling Ave.
*Waldo, H. L., 1834 Fifth Ave.

### RICHMOND COUNTY.

(NEW YORK.)

*No Society.*

NEW BRIGHTON.
Donovan-Conklin, Fannie C., 48 West.
TOTTENVILLE.—Coleman, David.
WEST NEW BRIGHTON.
Bryan, William.
Dawley, Lewis B.

### ROCKLAND COUNTY.

CONGERS.—La Roche, Pierre.
NYACK.—Couch, L. B.
Giles, J. Wm.

### ST. LAWRENCE COUNTY.

(‡*Jefferson County Society.*)

BRIER HILL.—Graves, Fred E.
CANTON.—Russell, G. A.
*Williams, Frank F., 6 Goodrich.
DE KALB JUNCTION.
Cole, E. M.
GOUVERNEUR.—Flint, W. J.
Haywood, C. W.
*Severance, B. W.
HEUVELTON.—Turner, Jason.
MASSENA.—Stearns, M. J.
NORWOOD.—Sumner, C. Oliver.
OGDENSBURG.
*‡Bell, W. N., 6 Greene.
Child, N. N.
Marsh, James M.
*Southwick, D. E.
POTSDAM.—Botsford, L. T.
Brown, H. D.

### SARATOGA COUNTY.

*No Society.*

BALLSTON SPA.—*Royal, T. Cook.
GALWAY.—Ingalls, Gilbert.
MECHANICSVILLE.
La Dow, Charles H.
ROUND LAKE.
Wilson, Maria L. D.
SARATOGA SPRINGS.—Ayres, Mrs.
*Pearsall, John A.
*Travers, O. J.
STILLWATER.—Taylor, George.
Smith, Sarah N.
WATERFORD.—Peckham, A. G.

### SCHENECTADY COUNTY.

(‡*Albany County Society.*)

SCHENECTADY.
‡Bates, Geo. W., 143 Jay.
*‡Faust, Louis, 19 Jay.
*‡Faust, William P., 22 Jay.
Fiske, Katrina C., 536 Liberty.
Gillette, Elizabeth, 22 Lafayette.
Liddle, Henry S., 1022 State.
Spoor, W. D., 168 Lafayette.
Towne, F. L., 17 Jay.

### SCHUYLER COUNTY.

*No Society.*

MECKLENBURGH.—Stobbs, A. V.
MONTOUR FALLS.
*McPherson, P. J.
Clawson, C. D.
WATKINS.—*Gulick, Wm.
King, Geo. H.
SLOANSVILLE.
*Vibbard, Arthur A.

(*Southern Society takes in all these counties.*)

### SENECA COUNTY.

*O. W. Peterson writes: "Society abandoned this day." Feb. 9, 1900.*

CANOGA.—Frantz, A. J.
SENECA FALLS.—Covert, R. B.
*Follet, W. M., 36 Cayuga.
WATERLOO.—Drake, M. S. (retired.)
Peterson, O. W.

### STEUBEN COUNTY.

*No Society.*

BATH.—Grant, B. F., Advocate Bldg.
CANISTEO.—Sutton, Frank L.
CORNING.
*Bryan, E. W., 22 W. Erie Ave.
Campbell, C. E.
*Purdy, Mark S., Highland Pines Sanitarium.
*Rodgers, A. H., 50 E. First.
HAMMONDSPORT.—Horton, J. T.
HORNELLSVILLE.
Hathaway, Mrs.
Hathaway, W. E.
Truman, I. P.
WAYLAND.—Piatt, A. A.

### SUFFOLK COUNTY.

(‡*Kings County Society.*)

BABYLON.
*Woodruff, A. J., 32 Main.
King, ——.
BAY SHORE (Long Island).
Proctor, Willis H.

GREENPORT.—Ireland, T. L.
‡Manaton, W. P.
HUNTINGTON (Long Island).
*Swords, Geo. P.
PATCHOGUE.
*Foster, E. Agate, Ocean Ave.
*Pettit, A. R., Main St.
RIVERHEAD.—Bleecker, Wm. H.
SOUTHAMPTON.—Pierson, John G.
SOUTHOLD.—Hartranft, Joseph.

### SULLIVAN COUNTY.

LIBERTY.—*Deady, Howard P.
LONG EDDY.—Leonard, H. K.
NORTH BRANCH.—Schonger, A. H.

### TIOGA COUNTY.

(‡*Broome County Society.*)

CANDOR.—*Van Ostrand, D. G.
NEWARK VALLEY.
*Bishop, Frank M.
OWEGO.—*‡Dutcher, Merritt T.
Gannett, G. J.
*‡Greenleaf, J. T.
*Merriam, H. E.
WAVERLY.—Beach, Belle R.
Hilton, W. M.

### TOMPKINS COUNTY.

ETNA.—Rood, Geo. L.
FREEVILLE.—Genung, Homer.
GROTON.—Baldwin, A. M.
ITHACA.—Beaman, C. P.
Besemer, H. B., 230 S. Albany.
*Besemer, Martin, 224 S. Albany.
*Crum, H. H., 212 Hazen.
Eadie, Andrew B.
Griggs, Elma.
Kirkendall, J. S.
Morgan, E. J., Jr.
*Nash, E. B.
Prentiss, Mrs. Adelina E.
LUDLOWVILLE.—Fish, Will.
TRUMANSBURG.—Terry, David P.

### ULSTER COUNTY.

*No Society.*

CLINTONDALE.—Birdsall, W. G.
ELLENVILLE.—Harris, Nelson A.
Smith, Henry C.
KINGSTON.
Chalker, A. P. (Rondout).
Coles, James C.
Connolly, W. Harry.
*Montayne, W. DeLa. (Rondout).
Steele, L. T.
NEW PALTZ.—Gerow, Stephen W.
ROSENDALE.—Van Demaark, John.
RONDOUT.—Starkey, Daniel T.
SAUGERTIES.—Wallace, Wm. I.

### WARREN COUNTY.

*No Society.*

GLENS FALLS.
*Birdsall, S. T., 142 Ridge.
*Bullard, D. H., 11 Elm.
Coffin, Henry W.
*Horton, C. A.
Little, G. W.
Paine, Howard S.
Smith, D. S.
*Wright, Amelia, 295 Glen.

### WASHINGTON COUNTY.

*No Society.*

CAMBRIDGE.—*Clark, L. A.
*Lewis, F. Edward.
EASTON.—Mosher, E. E.
FORT EDWARD.—Ball, Russell,
Mott, O. H. (Lic.)
Pattee, Raymond.
GRANVILLE.—Mosher, B. D.
GREENWICH.—Hulst, Peter H.
Mosher, E. E.
NORTH GRANVILLE.
*Spoor, D. E.
Tobey, C. M.
SALEM.—Russell, R. G.
SANDY HILL.—Infield, Clifford L.
Van Derwerker, H. W.
WHITEHALL.—*Horton, Ernest T.

### WAYNE COUNTY.

*No Society.*

CLYDE.—Childs, G. C.
*Hawley, L. B.
*Spire, Clayton E.
*Thorpe, Jarvis L.
MARION.—Halsted, Albert R.
NEWARK.—Parson, O. C.
Reed, J. A.
*Thatcher, E. P.
ONTARIO.—Peer, Thomas J.
PALMYRA.—McPherson, D.
SAVANNAH.—*Sweeting, W. H.
SODUS.—Hitchcock, C. T.
SOUTH BUTLER.—Mount, Garry.
WALWORTH.—Rodenberger, E. M.
WILLIAMSON.—Austin, A. G.
Clark, Frank Wake.
WOLCOTT.—Houston, S. Wilson.

### WESTCHESTER COUNTY.

*Annual Meeting, Yonkers, last Wednesday in January. President, N. Nutting; Vice-President, E. V. Brown; Secretary and Treasurer, H. G. Keith.*

DOBB'S FERRY.
*‡Hasbrouck, Joseph.
MAMARONECK.—Gerard, Louise.
*‡Hall, Matthew J.
Montgomery, R. W.



MOUNT KISCO.
*‡Miller, Carlos J.
MOUNT VERNON.
‡Ferris, I. W., 149 S. Third Ave.
†Haight, A. M.
*‡Ives, Nathaniel H.
†Jones, H. C., 220 S. First Ave.
‡Nutting, N., 210 Second Ave.
*Van Denburg, M. W., 107 Union Ave.
NELSONVILLE.—‡Winslow, W. J.
NEW ROCHELLE.
‡Finch, E. W., Center Ave. and Prospect.
Jenkins, Charlotte.
‡Kellogg, Fannie H., 172 Huguenot.
*‡Roberts, D. J.
*Weed, R. M.
NORTH TARRYTOWN.
*‡Brown, E. V.
PEEKSKILL.
††Mason, Perley H., 734 South.
*Greene, Chas. R. F.
PORT CHESTER.—*White, J. C.
Elmendorf, T. C.
SHRUB OAK.—Dresser, G. D.
SING SING.
*‡Lane, Irwin J., 2 Church.
*‡Madden, Joel D.
Schafmeister, John A.
WHITE PLAINS.—Birch, Chas. E.
*‡Kingsley, O. D.
NEW YORK, WILLIAMSBRIDGE.
‡Jones, Hattie.
YONKERS.
*‡Fay, R. P., 165 Warburton Ave.
Holden, George Parker, 175 Warburton Ave.
*‡Keith, Horace G., 107 S. Broadway
*Kenyon, W. B., (retired).
*‡Phillips, R. O., 275 Warburton Ave.
‡Stillwell, B. W. (retired).
*‡Trotter, R. R., 189 Warburton Ave.
White, H. H.

### WYOMING COUNTY.

ARCADE.—Hulett, Giles S.
Shedd, B. D.
ATTICA.—*Gifford, W. B.
Warren, S. G.
PERRY.—Hervey, C. R.
Pierce, Mrs.
PIKE.—Andrews, L. M.
WARSAW.—*Slaught, J. E.
WYOMING.—Wadsworth, Robert.

### YATES COUNTY.

ITALY HOLLOW.—Smith, E. D.
PENN YAN.—Cox, Joseph T.
Sampson, A. W.
Sampson, F. S.
DUNDEE.—Besemer, Arthur.

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