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TUBERCULOSIS.*

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(Concluded from April Bulletin.)

TUBERCULOSIS OF SPINE. Tuberculosis of the spine is commonly known as Pott's disease, but not in every case is tuberculosis the cause of Pott's disease. Pott's disease is a more general term referring to sharp or angular curvature and the most common cause for this is tuberculosis, although occasionally we get other forms of curvature in connection with some other disease; but inasmuch as tuberculosis is the most common cause of Pott's disease, it is frequently referred to as tuberculosis of the spine without reference to any cause for that character of deformity.

Tuberculosis of the spine is exactly the same disease as hip-joint disease; the cause and pathology, and a great many of the symptoms of this condition are the same as they are in hip-joint disease. It is very necessary that you be able to differentiate between tuberculosis of the spine and ordinary lesions, because the treatment of the two conditions is altogether different. If you were to give the same treatment in tuberculosis that you would in curvature you would do the patient much injury.

Etiology As in hip-joint disease, usually we have as one of the prominent causative factors injury or trauma. This, as a rule, precedes the development of the disease some little time, at least two or three months, sometimes several years. It may have been a sprain, injury, fall or blow; one of the most common causes is a blow,—one child jumping on another child's back and injuring it. After several months tuberculosis of the spine develops.

Heredity. Of course, in addition to this predisposing factor, we have the other predisposing causes, such as are present in a great many cases of tuberculosis of the bones; i. e., the individual susceptibility or the inherited tendency for these children to contract tuberculosis, there being a history of tuberculosis in the family, perhaps in the mother, as the mother is more apt to transmit the tendency

*Lecture delivered to 1910 Class in Practice.

than the father. The susceptibility is more marked where the tubercular history is on the mother's side of the family.

Injury and hereditary influence are the chief predisposing factors. Not that the disease itself is transmitted, but the susceptibility to the disease is inherited owing to the fact that a weakened nervous system or less resistant vitality is inherited from the parent.

Exciting Cause. The exciting cause, as in all other forms of tuberculosis is the tubercle bacillus. This gains entrance into the body usually through the respiratory tract or upper air passages. It gets into the lymphatic circulation, the venous circulation and finally passes through the heart and lungs and to all parts of the body as well. In this way the infection is distributed over the body; when the bacilli arrives at the point of lessened vitality, where the injury has not been great, but just enough to lower the resistance of the tissue, they proliferate, and cause the tissue to become necrotic and break down.

Symptoms. The symptoms of tuberculosis of the spine are not very marked, particularly in the beginning of the disease. The physical signs develop here before the symptoms. The child will not be lame in the back or suffer pain until you can detect on examination, as a rule, some slight deformity.

Physical Signs. The physical signs of tuberculosis of the spine are, first of all, abrupt or angular curvature. Say the disease develops in a child two or three years old. The child is running about and does not complain of any pain and apparently is in a good state of nutrition. The first sign of deformity is detected by the nurse or mother in bathing the child—in running the hand over the back she will detect a little prominence. Usually the deformity occurs in the dorsal region although we may have tuberculosis of the spine in the lumbar region or in the cervical region. It is most common in the dorsal, less common in the lumbar and least common in the cervical. It is apt to appear at the site of injury. The only thing to be noted is just one spinous process sticking out a little bit, perhaps a quarter of an inch. Perhaps up to this time the child has complained of no pain, can move his back pretty well and get up and down, but as the disease advances it is then that the symptoms begin to make their appearance.

Curvature. After a while, when the disease advances, you will see not only one spinous process sticking out half an inch or an inch, but the one above or below it will begin to project a little also, forming quite an angular curvature, involving four or five

vertebrae. The vertebra where the disease started is the one which continues to be the most prominent, however.

As the disease advances the curvature becomes more marked, and perhaps after a while it will involve three, four or five vertebrae, or even as many as ten. The deformity becomes more and more marked and finally permanent. Deformity can never be entirely relieved unless taken right in the beginning when it is hardly noticeable.

Other Signs. In addition to the physical signs of deformity there are other signs. Shortly after the first spinous process begins to project, the child will show evidence of rigidity in the region of the diseased area. This is an effort of Nature to make a fixed point—to wall off the part with fibrous tissue and to give it as much rest as possible. The child will not get up and down, nor be so lively on his feet as formerly. In playing with other children he will stand off to one side, will not get in the mix-up because it hurts his back. In picking up anything from the ground he will get down by putting his hands on his knees, and will straighten up in the same way. His back is sore and stiff and he does not want to move it. In the early stages make a thorough examination of the spine. Have the child sit up. Reach around under his arms and try to get motion all along the spine. If you find a little posterior deformity, in which you cannot get motion and if it is painful when you attempt it in that part of the spine, it is a pretty good sign that the child is developing tuberculosis. There is some pain on pressure, particularly if you attempt motion at that place where the spine is most prominent.

Those are the principal physical signs: deformity, rigidity, the way the child handles himself in getting up and down, his disinclination to move the spine, and general tendency to keep as still as possible. The symptoms are, more or less pain in the spine,—not a great deal; occasional restlessness at night. He cries out, though not nearly so often as in hip-joint disease. In some cases patients will rest quite well during the development of the disease, and do not cry out as they always do in cases of hip-joint disease. In about half of the cases they do not sleep well and wake up scared.

Pain in Abdomen. Another symptom is pain in the abdomen. Usually the little fellows are pot-bellied, the abdomen becomes prominent and hangs down, and on account of the deformity in the back, particularly if it is in the dorsal region, they will suffer from pain in the abdomen. At times it will be quite acute, and distributed throughout the abdominal viscera.

General Health. The general health as a rule is not affected greatly, though it is somewhat impaired. It depends upon two things, (a) the extent of the deformity, and (b) whether or not the tubercular infection is complicated by mixed infection. Where the deformity is not marked the general health is not much impaired, especially where early treatment is commenced to prevent further deformity and correct what already exists. These children feel good, suffer no pain from treatment, are not reduced in vitality or flesh and make complete recovery as a rule.

If the disease advance until it involves half a dozen vertebrae, and if there is large posterior angular curvature, ribs thrown down and piled up on one another, with frequently the last rib sticking into the pelvic bone, the patient's general health will be affected.

Complications. Tuberculosis of the spine may be complicated with mixed infection, just as tuberculosis of the hip may be, and pus will form.

Abscess. There are two or three common sites for abscess in connection with tuberculosis of the spine. Abscesses may appear anywhere around the hip-joint. In the back they manifest themselves as either dorsal or lumbar abscesses arising in diseased tissue and pointing behind; they are chronic and usually run until the disease becomes quiescent.

Psoas Abscess. There is another form known as psoas abscess occurring in the lower dorsal or upper lumbar. The psoas muscle attaches in that region and frequently when the disease makes its appearance in the fore part of the body of the vertebra this muscle is involved; an abscess forms and extends down the sheath of the psoas becoming perhaps, as large as a croquet ball. After following the muscle to its insertion it terminates on the inside of the thigh close to the pubic bone and there breaks.

Psoas abscess is not an uncommon complication in connection with Pott's disease. Some times the abscess is treated surgically by running a long handled spoon up the muscle to the back bone. Psoas abscess will become quiescent after the tuberculosis has subsided.

Differential Diagnosis. We have a good many other different diseases of the bone but they are comparatively rare,—tuberculosis is the most common.

There is another bone disease called osteomalacia—softening of the bone. It is not a tuberculosis of the bone. It is not inflammation of the bone as tuberculosis is, but is a softening. From some nutritional

disturbance the mineral matter of the bone is absorbed, leaving the spine very soft; as a result, parts of the thorax, spine and ribs collapse, and we have a very marked deformity. This disease is rare.

There is also marked deformity in connection with other forms of inflammation of the bone. Inflammation following typhoid fever produces a bad deformity; rickets in children also produces the same result and should not be confused with tuberculosis, because not only the spine, but the ribs, bones of the leg, wrists, and the bones of the entire body are affected. Differentiate particularly between tuberculosis and ordinary simple curvature.

Lateral Curvature. The most common curvature that occurs without inflammation or disease of the bone is lateral curvature. In treating patients we frequently find a posterior or anterior curvature, but never to any great extent. Sometimes we find a posterior lumbar and anterior dorsal, or an anterior lumbar, and posterior dorsal but never so much deformity as we find in lateral curvature, where there is a marked curve which is not due to inflammation of the bone. In cases where the lateral curve is quite marked you will be unable as a rule, to tell the original point of curvature, because we never find a single curvature of the back. If you find curvature in one region to the right, you will find another curvature to the left in another region, and it is always difficult to tell which is primary and which secondary or compensatory, because usually these two curvatures are of about the same size. As between Pott's disease and simple curvature, in every case of Pott's disease your primary deformity is posterior.

You have only a posterior curvature in tuberculosis. There is no tuberculosis in the spinous processes because that bone is hard. Sometimes the disease begins in the intervertebral disc, but it usually commences in the fore part of the body of the vertebrae.

Limitation of Motion. In every case of tuberculosis you find limitation of motion. In fact in the diseased area you cannot get any motion, particularly after the disease is pretty well advanced. Attempting motion will cause great pain. In simple lateral curvature you are usually able to get more or less motion. While of course the movement is limited, still you are able to get it, to quite an extent, especially by lifting up on the back, unless the disease is of many years standing. If only of a few years standing you can correct the lateral curvature by good treatment. This you cannot do in angular curvature of the back because the bone is wasted away. In connection with this posterior curvature in tuberculosis frequently we have, in

addition, a little swerving to one side. The curvature is not always right straight back. It may be a little to one side although it is posterior.

We always have a rotation of the bodies of the vertebrae in connection with lateral curvature. On the prominent or convex side the vertebrae rotate outward, or in that direction. In addition to the lateral swerve we always have rotation of the bodies of the vertebrae, and they rotate toward the curvature. If the curvature is to the right in the dorsal region, the bodies will be rotated to the right side outward and backward, on the convexity of the curvature, while in the concavity, the ribs are thrown inward.

TREATMENT. To illustrate the treatment I will tell you of the case of a child that we treated here for tuberculosis of the spine. He had a small knuckle sticking out, and instead of trying to get motion in it we put him on a rack,—that is took the top off a treating table, tacked a piece of muslin over the frame and put him on that, face down. After placing him there I had some one help me and we stretched him a little; when he was well stretched out I pushed the prominent vertebra down;

and because of the early stage of the disease, I corrected it somewhat. (There is only one condition where it will do to correct the diseased bone, and that is where you keep it quiet afterward. To attempt to correct it and then let the child up is simply irritation. If you ever attempt to correct a diseased bone, do it and then keep the patient perfectly quiet.)

We straightened the back, pushed the deformity down, and with the patient in the hyperextended position, put on a light plaster cast. We kept him on the table about an hour until the cast set, then had him lie down for a few hours, when his mother took him home. He was up and running around within a week

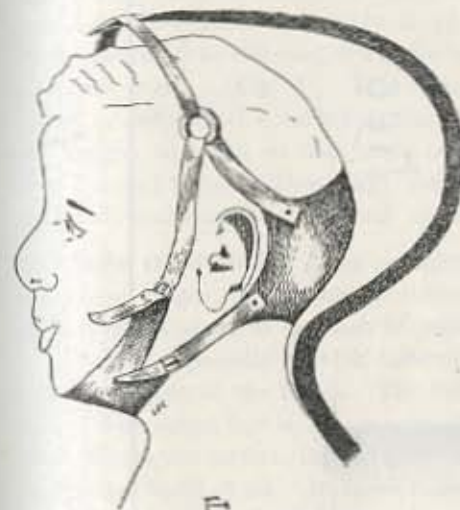


FIG. 5 illustrates a "jury mast" made to support the weight of the head in cases of tuberculosis of the cervical vertebrae. The steel mast from which the leather fitting is suspended is removable and adjustable by a set screw at its base, and may be taken off at night when the child is ready to retire. The base of the mast is supplied with two or three metal ribs on each side which are firmly encased in a plaster cast snugly covering the thorax.

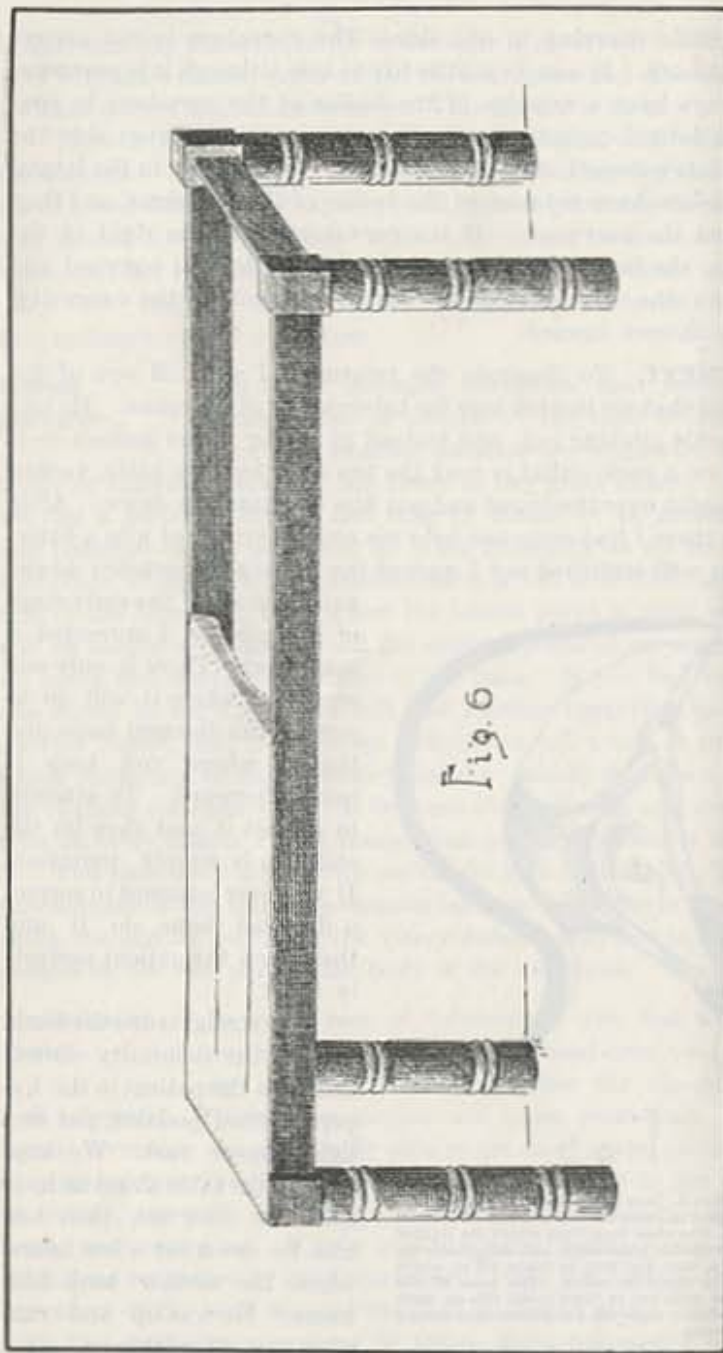


FIG. 6 shows a jury mast, treating table with the top removed, and masts is backed over sufficient length to accommodate the child's body. The child is placed face downward as described in the accompanying article, and two slits cut in the cloth at either side of the body. Through these the plaster bandages are passed, (as well as the dry bandages later) and when the cast is completed, the mast is completed, the mast is cut across and the portion upon which the child lay is included within the cast.

and felt just as well as ever. He could not hurt his back because of the cast on it; it was protected even if he fell down.

In two or three months we took the cast off, and the spine was entirely well,—deformity corrected and disease quiescent; that is common sense treatment. Where you have inflammation of the bone, it is only common sense to fix the part due to tuberculosis and keep it quiet. Gouging it around, twisting and pulling it, which might be excellent treatment in some ordinary lesion, is just wrong in tuberculosis.

You can readily see the necessity of differentiating between tuberculosis and ordinary lesions which might be as big as the beginning lesion in Pott's disease and simple curvatures. Never manipulate a tubercular joint while the disease is active. Let the manipulation occur after the disease is quiescent; then if possible, get more motion. If you follow that plan you will get the best results. If you do some other way you will get bad results.

TUBERCULOSIS BONES OF THE NECK. Now and then you will find a case of tuberculosis of the bones of the neck. In such a case it would not be feasible to apply a plaster cast, but as the diseased vertebrae must be relieved of weight-bearing, we use an appliance known as a jury mast. (Fig. 5). This consists of a steel mast, or frame, from which is suspended a leather rigging, into which the head is slung, and the height adjusted so that none of the weight of the head rests upon the diseased bones. These jury masts are made to order from measurement, and may be obtained at instrument dealers.

LOSS OF VOICE. Does complete loss of voice ever occur in the advanced stages of pulmonary tuberculosis? If recovery from tuberculosis takes place, is the loss of voice permanent?

This is especially true in tuberculosis of the throat—more so than in tuberculosis of the lungs. The voice becomes weak where the lungs are in bad shape but is not necessarily lost. However, where tuberculosis affects the larynx, the voice is lost and the patient may not be able to make a noise at all. In those cases the patient never recovers. It is one of the rapidly fatal forms.

TYPHOID FEVER.

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[Concluded from April Bulletin]

Its biological features, so far as they have been determined, correspond to those of the Eberth-Koch-Gaffky bacillus, or "typhoid bacillus," which organism for practical purposes may be, and at present should be, accepted as the specific causative agent of typhoid fever. Therefore, in the adoption of measures to prevent the disease we should consider not only the bodies of infectious persons as constituting primary sources of infection, but also the various vehicles, such as water, fingers, foods, flies, etc., which after receiving the specific organisms contained in the discharges from infectious persons may constitute immediate sources of infection.

Preventive measures carried out in accordance with this view have, in every instance in which sufficient thoroughness has been exercised, proved successful.

It is possible that there are some as yet entirely unknown factors in the etiology of typhoid fever, particularly among those concerned in the establishment of individual susceptibility to the infection, which if known might have a practical bearing on measures to prevent the disease; but in the science of sanitation, as in other sciences, there is no justification for postponing the application of present knowledge because the future may hold important discoveries.

The methods of preventing typhoid fever which are now considered the best may appear some time in the future to be crude, but such speculation affords no excuse for failing to carry out these methods provided they are justified by the promised results. There is no longer any room for reasonable doubt that preventive measures based on present knowledge of the subject are effective, and as the expenses and inconveniences incident to their enforcement are insignificant when compared with the beneficial results which they have been proved to accomplish, there seems to be no excuse for any community to fail to have these measures thoroughly carried out.

For the local health officer the two principal plans of action to prevent typhoid fever in his community should be as follows:

(1) The prevention of the spread of the infection from persons in the community who harbor the infectious organisms (typhoid fever patients and typhoid bacillus carriers);

(2) The prevention of the introduction of infection into the community from without through various channels, such as the water supply, the milk supply, and the general food supply.

In efforts to carry out either of these plans of action a number of

practical difficulties will be encountered, but the ability of the health officer to overcome just such difficulties is the best index of his efficiency. It has been said that every community under a democratic form of government has as good public officials as it deserves. There is no public official who can do more to make his community more deserving in respect to the usefulness of his office than can the health officer.

The average intelligent citizen will consider carefully the reputed skill of the surgeon to whom he is to submit himself or some member of his family for a surgical operation, but as a rule will pay little or no attention to the administration of the health office, on which the health of his whole household in a way depends continually, so long as such administration does not interfere with his business or cause him some personal inconvenience. It is human nature to take steps to avoid immediate and evident dangers, but to trust blindly to chance to avoid those which are apparently remote but no less real.

In many cases of typhoid fever a positive diagnosis can not be made from the symptomatology alone until the end of the second week of illness or later. In some cases, running a mild or an irregular course, the most skilled clinician, without the assistance of laboratory tests, may not be able to make a perfectly positive diagnosis even after having had the cases under observation throughout the attack. In frequent instances infection is discharged from typhoid fever patients from the very beginning of illness. Therefore it is highly important to begin precautionary measures early. This can not be done in many cases if the establishment of a positive clinical diagnosis is waited for. The early adoption of prophylactic measures in one or two undiagnosed cases may prevent an epidemic. The health officer should endeavor to get the physicians or other persons in charge of a person suffering from or presenting symptoms suggestive of typhoid fever to report the case to the health office as one of recognized or suspected typhoid fever within twenty-four or forty-eight hours after taking charge of such person.

In communities where the greater part of the infection is not introduced from without through water supplies, milk supplies, etc., the bed-sides of patients as a rule constitute the principal source of infection. The Typhoid Fever Board of the Public Health and Marine-Hospital Service reports that of the cases of typhoid fever originating in the District of Columbia during the seasons (May 1 to November 1) of 1907 and 1908 about 20 per cent gave a history of direct or indirect association with previous cases in the febrile stage of the disease, and were

attributed to contact infection. Similar findings, no doubt, could be obtained in other communities in which the infection now is regarded as being almost entirely, if not entirely, water-borne.

The destruction of the infection at the patient's bedside is a comparatively simple undertaking, but once the infection is allowed to escape from the patient's room, the tracing of it and the destruction of it are, under the complex conditions of urban life, very difficult, if not impossible.

The local health officer should endeavor to secure the enforcement of proper prophylactic measures at the bedside of every typhoid fever patient in his community. The patient should be reasonably isolated and efficient disinfectants should be used in an efficient manner. If these things can not be done properly at the patient's residence, the patient should be sent to a hospital for treatment. The health officer should be legally empowered to have these measures carried out; if he is not so empowered he can accomplish a great deal by the use of moral suasion on the family and the attending physician of the patient.

Practicing physicians, as a body, should not be depended on to advise and have carried out the prophylactic measures. Some practicing physicians are not properly informed on the subject; others will not take the time and trouble; and some, fortunately a decided minority, will inform the family that the use of disinfectants is unnecessary because "the medicine being given kills the germs in the patient."

Of about 2,000 cases treated at private residences and investigated in the District of Columbia during 1906, 1907, and 1908, the use of disinfectants in stools and urine was efficient for only about one-third. All of these cases were attended by and had been reported by physicians. The figures make a rather poor showing, yet probably a better one than would figures similarly obtained from the average community in the United States. A health officer in visiting a home for the purpose of preventing the spread of infection from a typhoid-fever patient should make his instructions to the family plain and practicable. He should become assured that the disinfectant solutions are made properly and used properly. In many instances by making two or more visits to the home he can accomplish results which at his first visit appeared highly improbable.

The majority of typhoid fever convalescents, by the time they are able to walk around, no longer discharge typhoid bacilli in their dejecta. Some persons, apparently entirely recovered from the disease, however, continue to discharge typhoid bacilli in their urine or feces or in both, for months or even years. From the results of rather exten-

sive bacteriologic examinations by Lentz, Klinger, von Drigalski and others, it may be estimated that about 3 per cent of persons who have typhoid fever become chronic bacillus carriers.

Specimens of feces and urine from 307 persons who had had typhoid fever in the five years previous were examined bacteriologically at the Hygienic Laboratory in Washington during 1909, and 8, or about 2.5 per cent, of these persons were determined to be bacillus carriers.

Probably a good many more than 3 per cent of persons recovered from typhoid fever continue to discharge typhoid bacilli for two or three weeks after convalescence is established. On general principles the use of disinfectants in the stools and urine of typhoid convalescents should be continued for at least two weeks after defervescence, and, whenever practicable, bacteriologic examinations of the dejecta should be made and the convalescent not discharged from the supervision of the health officer until at least two such examinations have given negative results for the typhoid bacillus. Such bacteriologic examinations should be made a requirement for all cases treated in hospitals, cities, towns, and other places where properly equipped laboratories are available. Every city health officer should have a laboratory equipped for such examinations. If a law requiring the examination of specimens from typhoid convalescents can not be secured immediately, the health officer can obtain the specimens in the vast majority of instances after properly explaining to the patient, the family, and the physician the importance of having the examination made.

Typhoid bacillus carriers in a community may be discovered (1) by making bacteriologic examinations of specimens of feces and urine from all persons who have typhoid fever and who on request will submit specimens. (2) by the epidemiologic study of cases of typhoid fever. A series of cases in a household, with some of the intervals between cases too long for the cases to be accounted for by contact between patients, is suggestive, and specimens should be obtained from those who have had typhoid previous to the case under investigation. An unusual occurrence of cases among persons supplied with foods or beverages from certain grocery stores, bakeries, or dairies should direct attention to the personnel of such places. In the course of the study a directory of the house servants employed in the homes of cases should be kept, and if it is found that typhoid frequently occurs in homes at which certain servants are employed specimens from such servants should be examined.

After bacillus carriers are discovered, what to do with them becomes a difficult problem. These persons, as a rule, are in apparently good

health and able to pursue their vocations and avocations. To require a strict isolation or quarantine of them as a class would be decidedly radical, almost as radical, in fact, as it would be to require the isolation of all cases of incipient pulmonary tuberculosis. The health officer should be given legal authority (1) to place and hold in quarantine any typhoid bacillus carrier who will not take or who from lack of intelligence can not be expected to take the necessary precautions prescribed by the health officer, to minimize to a reasonable degree the likelihood of infection being spread from the excreta of the bacillus carrier; and (2) to prohibit any typhoid bacillus carrier whatsoever from engaging in certain occupations, such as will involve the handling by such persons of foods and beverages for public sale and which are usually eaten or drunk without cooking subsequent to purchase. In lieu of such authority the health officer here can use moral suasion to good advantage in the vast majority of instances. The intelligent and conscientious person who is a bacillus carrier, if properly informed as to his condition, will take precautions to keep from spreading the infection. The average intelligent person, with an understanding of the danger from bacillus carriers, will not employ a bacillus carrier to work in a bakery, restaurant, dairy, grocery store, or in the dining room, kitchen, or nursery of his family. It would certainly seem no more than fair to have legal provision made for reasonable compensation of any bacillus carrier who on account of the restrictions imposed would be seriously hindered in the earning of a livelihood.

Typhoid fever may be spread from the dejecta (1) of persons in the early stages of the disease and who have not become ill enough to take to bed; (2) of persons who remain ambulant throughout the attack; (3) of convalescents (acute bacillus carriers); and (4) of persons who, though apparently in good health, are either temporary or chronic bacillus carriers. In order to safeguard the family and the community against these sources of infection, it is necessary to have the sewage of all persons—the sick and the well—properly disposed of.

The lack of water-closets or privies and the use of faulty water-closets or privies in a community constitute a grave menace to public health. Infection in excreta improperly disposed of may be carried by drainage or seepage, or on the feet of chickens, hogs, dogs, cats, etc., to the local water supply. It may be conveyed by flies and other insects, and by fingers directly to foods in the kitchen or dining room or to the mouths of persons. The scattering of human excreta along railway lines from the very faulty "sanitary" arrangements on passenger coaches constitutes an entirely unnecessary danger which should be

corrected by legislative enactment. In communities unprovided with good water-carriage sewerage systems, health officers should strive unceasingly to secure the adoption of safe methods of sewage disposal. If the pail system or the dry-earth closet system has to be used, a model privy should be kept on exhibition at the health office. The health officer, by all means, should have at his own home a properly constructed and managed privy. What the health officer does to protect his own family frequently will impress the people more than his official proclamations.

To determine the importance of these supplies as factors in the spread of typhoid infection careful, and in some instances prolonged, epidemiologic studies are necessary. The results of bacteriologic examinations of the water and milk supplies may give helpful information, but as a rule more can be gained by a field investigation, including a sanitary inspection of the watershed, the milk shed, the truck farms, and the oyster beds, and by an investigation of the individual cases of typhoid fever to determine the sources of water, milk, vegetables, shellfish, etc., used prior to illness.

The health officer can, and should, make these investigations, and by doing so he will be able as a rule to determine the principal sources of infection. A number of very practical obstacles may be encountered in trying to have the infection from without the community safeguarded against, but by persistently keeping the facts before the public, the health officer can succeed in the vast majority of instances in securing the sinews of sanitation—money—necessary to the establishment of such safeguards, even if the safeguard necessary be a costly filtration plant or a municipal pasteurizing plant.

OSTEOPATHY VS SURGERY IN APPENDICITIS.

S. S. STILL, D. O., LL. B., LL. M.

(Continued from April Bulletin.)

Of the seventeen periodicals professional, political etc., that came to my desk today sixteen contain something that I would gladly quote, because of interest to the profession, but I content myself with the following from the Medical Era for April:

The quotation is from the first article which is an editorial under the title "Our Waning Prestige." "At this time the medical profession is being subjected to the hardest trials it has experienced since medicine was put on its present high plane" *** "It is plainly evident that we do not possess the confidence of the people as we did at one time and we must bend every energy to retain it" ... Not long ago I read in one of the daily papers a communication which while amusing in its apparent endeavor to lay many strange deaths to the physician, showed plainly

the attitude of the general public at the present time. In this letter the writer called attention to the large amount of newspaper space devoted to the trials of physicians who are supposed to have made use of their professional knowledge to dispose of persons whose existence prevented the enjoyment of fortunes or women.

I give the extracts to show how far the able editor of a leading medical journal has missed the cause of the lack-of-confidence vote which the American people have given to a once honored and trusted profession. The people have learned that every pain in any of the great cavities of the body is not necessarily caused by appendicitis and that an appendectomy is not the only or even the best remedy. To such an extent is this truth known by the laity that many call an osteopath at once, when the family medical physician diagnoses a disease as appendicitis and advises an operation. They ask first if it is appendicitis; in a majority of cases he is compelled, to say it is not. When it is, they want him to decide if an operation is necessary. Truth again compels him to decide in the negative in a vast majority of cases. As I said in a former article I have never sent a case of appendicitis to the surgeon or to the undertaker and my experience is the same as that of many other osteopaths.

Just here a newsboy brings in an extra announcing that King Edward died at 11:45 p. m. It is now only 7:45 p. m. I hear of the King's death apparently four hours in advance of its occurrence yet some good people oppose the use of electricity in transmitting news—they prefer Simon-pure oral and five fingered news transmission. But I digress. I would not have mentioned the King's death were it not for the fact that I had occasion to refer to him in the first article of this series and the additional fact that on Monday while enroute from Kirksville to Des Moines a commercialman, who makes the "M Quad", Moulton, Mason, Moberly and Mexico called attention to a statement that I made at the Iowa State Osteopathic Association two years ago. The statement was in effect that operations were as justifiable in inflammation of the lungs including sequelae as of the appendix, under like circumstances. This commercialman reported a conversation he had held with an appendectomist while visiting a town in Northern Iowa. The latter became very angry while telling the commercialman what he had seen in the newspapers, quoted from my speech. I then told him that I had modified my opinion; he looked somewhat disappointed as he had supported my position, but seemed much pleased when I explained that I had modified my opinions in the right direction. My explanation is this, spontaneous relief is perhaps more frequent in abscess of the appendix than in abscess of the lung hence I would advise operation in a greater percent of cases of pneumonitis than of appendicitis. I am deeply interested in these two diseases. King Edward recovered from the latter and died from the former. I consider the former by far the more serious disease.

I do not have the prejudice against medical doctors that some enjoy. I recognize that they are not all bad, but there are good, bad, and indifferent among them. I know that they are almost a unit in attempting to keep from the general public the truth in regard to appendicitis. Some do this from ignorance, some because of self interest, some because they have been misled by the authority of a great name or of a great

medical journal. A few days since I noticed the report of a certain number of deaths in Iowa for the past month from various causes including those from appendicitis. I wrote Dr. Guilford H. Summer, Registrar, and received a courteous reply by return mail. The vital part of his reply follows: "State of Iowa Dept of Vital Statistics, Des Moines, Iowa * * * "In reply will say that it will be impossible for us to give you the number of persons who were operated upon for appendicitis in an effort to save them. This is never put down on the death certificates, the cause of the death being simply "Appendicitis." I have a like reply to a similar interrogatory sent about two years ago to Dr. Summer's distinguished predecessor, Dr. L. A. Thomas. The reason why I insist that those who die from operation should be kept separate from those who die from the disease is obvious from the following quotations: "Des Moines, Apr. 29, 1910, Miss expires following operation from appendicitis, funerals awaits arrival of parents, who have been summoned" "HongKong Apr. 15" An operation for appendicitis resulted today in the death of William A. Rublee, the American Consul General at this point." The cases of Dr. G. T. Twyman, witness in Hyde case is known to your readers. "Kansas City, Apr. 18 The operation performed yesterday morning was a success and the patient made such a rapid recovery that he was believed to be out of danger. Later, his pulse became weaker. Still later, he died."

"Houston, Texas, Apr. 19, Miss Weston, formerly of Des Moines died following an operation for appendicitis."

"Scranton, Pa., Apr. 19, Ernest Smith formerly of Des Moines died in a hospital following an operation from appendicitis."

Is it not appalling to look on that and then on this. "At the recent international congress in Europe, an American physician and surgeon of established repute, assailing the too free use of the knife in cases of appendicitis declared in all of his twenty years of practice he had never seen a patient die from appendicitis. And he called upon the members of the congress to say whether they ever observed a death from appendicitis, and not one of them answered that he had."

The diagnosis and treatment of appendicitis will be the subject of the next article. The former is often most difficult the latter generally exceedingly simple. The first case I recall was one of mistaken diagnosis. Two surgeons had diagnosed "rupture" and had applied a truss. I was seventeen years old and was "practicing" with my father who was called in consultation. He at once pronounced the "tumor" an abscess and not a hernia. The young physician in charge ridiculed the proposition. An eminent surgeon of Lawrence Kansas was sent for to decide. The next day we again met at the patient's home. Both surgeons agreed that father should open the abscess. The attending physician actually "made faces" when father prepared to make the incision, but he made worse faces when the pus began to flow declaring most dramatically that the case had "changed materially" since the preceding day, (sic!) *passim*.

Recently a case of psoas abscess was variously diagnosed as appendicitis, hernia, coxitis, (hie!) et ubique.

COCCYGEAL LESIONS.

F. P. MILLARD, D. O., TORONTO, CANADA.

Although a very small bone, the peculiar location of the coccyx renders it liable to subluxation. It is not uncommon to see cases suffering with coccydynia, or even cases where coccygectomy had been advised, and sometimes performed. This rudimentary caudal appendage often proves as troublesome as the vermiform appendix.

One of the most annoying cases of cystitis I remember treating, during my ten years of field practice, was caused by a coccygeal lesion following dystocia. The nurse, through instruction given by the attending physician, had been irrigating the bladder every few hours, which only proved an aggravation, setting up inflammation, the patient suffering untold torture. An examination revealed a posterior condition of the coccyx, indicating that external manipulation was sufficient. With thumb placed over the sacro-coccygeal articulation, a single movement was all that was required, and within a few moments' time the sharp cystic pain abated and did not return.

Another case of subluxated coccyx, resulting from parturition, which came under my attention some two years ago, had been suffering for some months, more or less constantly with cystic and genital pains. The pain was sufficiently severe during the night to keep the patient awake for some hours at times. Associated with the misplaced coccyx was a posterior lumbar condition, but the pain seemed to leave after correction of the coccygeal lesion, and before the lumbar lesions were entirely corrected, denoting that the major part of the trouble arose from the coccygeal lesion.

At no point in the sympathetic chain is one of its ganglia subjected to such a degree of misplacement as that of the ganglia of *Impar*, located immediately in front of the coccyx. A severe misplacement of this bone renders this ganglion liable to pressure or traction through its association with surrounding tissues. Reflexly, many symptoms may arise from disturbances of this ganglion, such as pelvic disturbances, cephalic congestion, etc. Associated with this ganglion on the sympathetic, we find communicating (Fig. II.) fibres of the coccygeal nerves, and if disturbed by the osseous lesion, produces additional reflex symptoms by way of spinal nerve fibres in the cord.

The most annoying lesion in many instances is the anterior misplacement of this bone, (Fig. I) as it produces mechanical pressure and interference with the rectum, causing a partial artificial pocket to form above the internal sphincter, allowing the accumulation of fecal matter

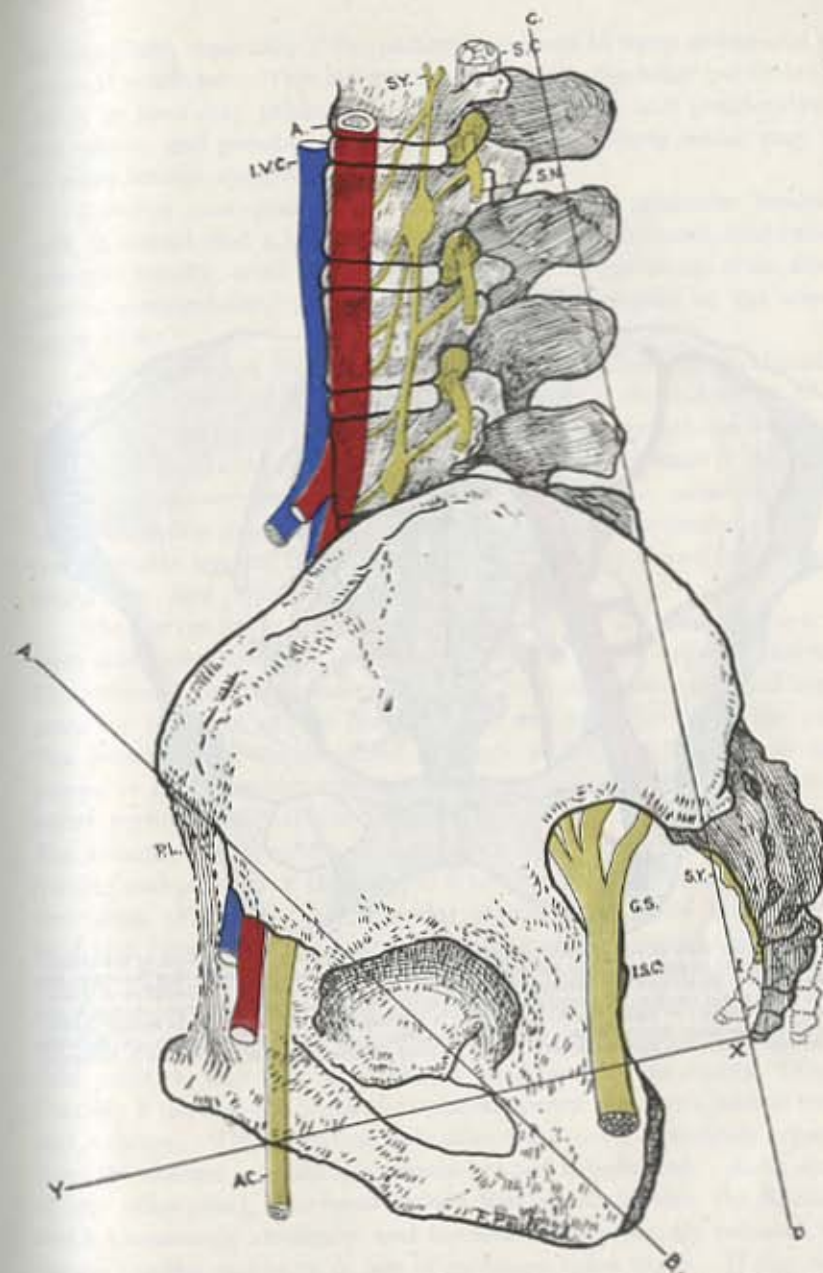


Fig. I.—Side view of the innominate, sacrum, and coccyx, showing anterior and posterior subluxations of the coccyx, at the sacro-coccygeal articulation. The point X represents the normal position of the tip end of the coccyx. C, D. Perpendicular line passing through X. Y, X. At right angles of C, D. The line A, B. is a common diagnostic line passing through the anterior superior crest of the ilium and the tuberosity of the ischium. S. C. Sacro-coccygeal. S. S. Sympathetic chain. S. N. Spinal Nerve, emanating from the spinal cord as shown through the intervertebral foramina. G. S. Great Sciatic Nerve passing over the spine of the ischium (I. S. C.). A. C. Anterior Coccygeal Nerve in relation to the femoral artery and vein. P. L. Pogon's ligament. I. Ganglion coccygeum impar, the lowest ganglion in the sympathetic chain. Anterior or posterior subluxations of the coccyx disturb the normal position of this ganglion more than any other ganglia, in the sympathetic chain, unless it be the inferior cervical ganglia, when deflected by the head of the 1st rib.

to take place, especially if the patient is subject to more or less of a constipated condition. This in turn interferes with the other pelvic organs, which in time may produce congestion, thickening and proliferation of the tissues, and possibly result in abnormal conditions which may lead to more serious symptoms.

Anterior coccygeal lesions often disturb the sphincter tissues to such an extent that a haemorrhoidal condition is produced, and remains constant usually, until the lesion is corrected. Pruritis ani often accompanies haemorrhoidal symptoms through involvement of the sensory nerve fibers.

Sacro-coccygeal lesions are not always produced by subluxations or misplacements of the coccyx. Sometimes a displacement of the sacrum will affect the articulation, resulting in symptoms similar to those of a dislocated coccyx. In determining which bone is responsible for the sacro-coccygeal lesion, a careful examination must be made of the relationship existing between the sacrum and the innominates, also the muscular tension in connection with the coccyx, and the degree of tenderness and resulting disturbance.

The nerves around the coccyx are mostly of a sensory nature, and coccygeal lesions usually produce disturbance of a sensory character. The perineum receives sensory branches from the sacro-coccygeal nerves, posterior branches of the lower sacral, and branches from the pudic. The formation of the foramen, through which the fifth sacral nerve passes, is made by the two cornua of the coccyx connecting with the sacral cornua, and held in position by the sacro-coccygeal ligaments. The articular arrangement of the coccyx is in the form of a hinge joint, making mal-position of the coccyx, if not too marked, in antero-posterior directions. (Fig. 4.) The muscular attachments cause the coccyx to be drawn forward or backward, depending on the physiological circumstance. The sphincter ani muscles draw forward, while the gluteus maximus draws it backward and slightly to the side involved. Here we find a condition not described in books generally, but noticed in field practice, and that is a rotated condition of the coccyx. (Fig. 6.) Possibly a third of the cases of displaced coccyx indicate a lateral tension and rotation. This can occur only after the coccyx is partially separated from the sacrum, so that the cornua are not interlocked. As in sprains of any other point, coccygeal lesions first of all involve the ligaments, and if too severely stretched, and the lesion not promptly reduced, these tissues thicken and more or less of irritation takes place. If the coccygeal tissues becomes inflamed and a rheumatic tendency already exists in the patient, there are likely to be deposits, resulting in pseudo-

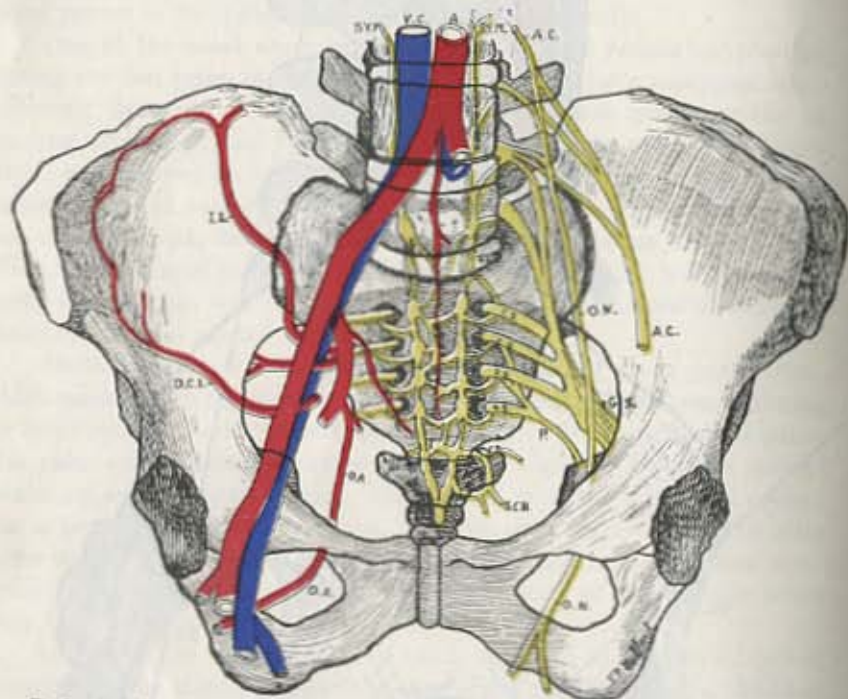


Fig. 2.—Anterior view of 4th and 5th lumbar, sacrum, coccyx, showing the position of the sympathetic nervous chain in relation to the sacro-coccygeal articulation, also the connection between the sympathetic chain (Sym) and the spinal lumbosacral and coccygeal nerves. I. Ganglion of impar, located in front of the coccyx. C. Coccygeal Nerve. S. C. N. Sacro-coccygeal nerve. A. C., A. C. Anterior Crural nerve. P. Pudic nerve. O. N., O. N. Obturator Nerve. G. S., Great Sclatic Nerve. Sym., Sym. Sympathetic Nerve chain. A. Abdominal Aorta. V. C. Inferior Vena Cava. S. M. Sacra Media Artery. I. L. Ilio lumbal artery. D. C. I. Deep Circumflex Iliac artery. O. A. Obturator artery.

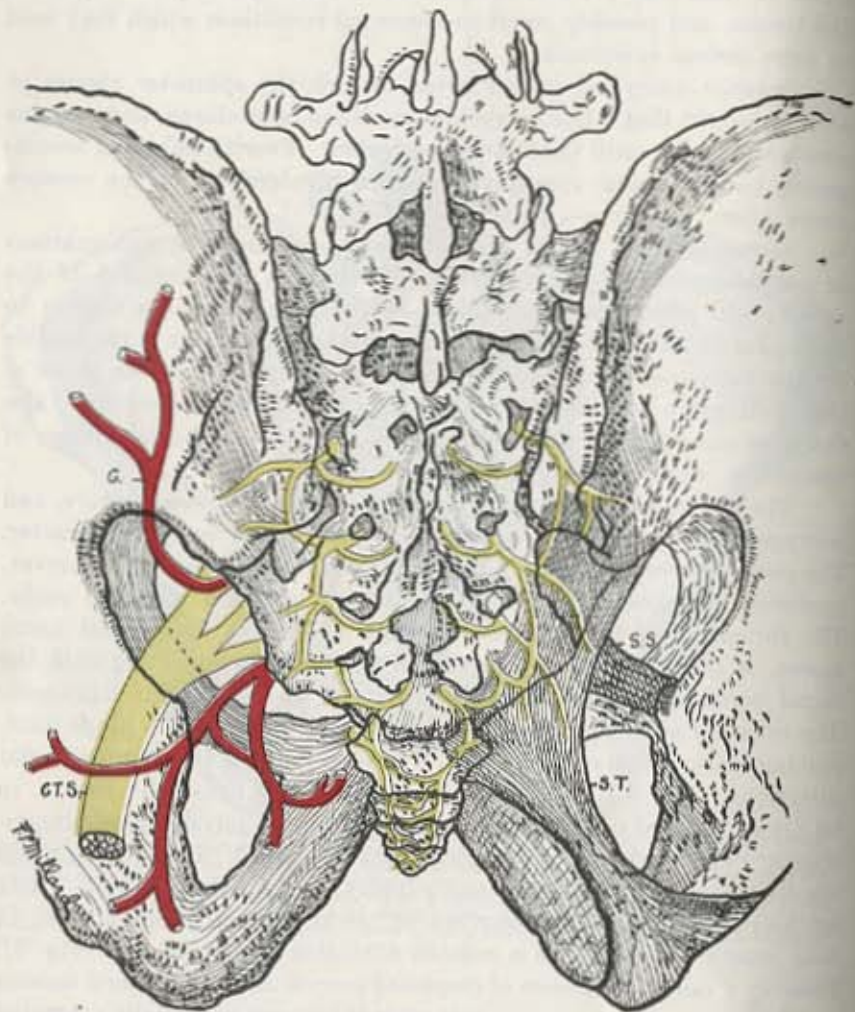


Fig. 3.—Posterior view of the sacrum and coccyx, showing ligamentous attachments on right side. S. S. Sacro-spinous ligament. S. T. Sacro-Tuberous (great sacro sciatic) ligament. G. S. Great Sciatic Nerve. Gluteal Artery. Posterior sacro plexus is shown, also the coccygeal nerve.

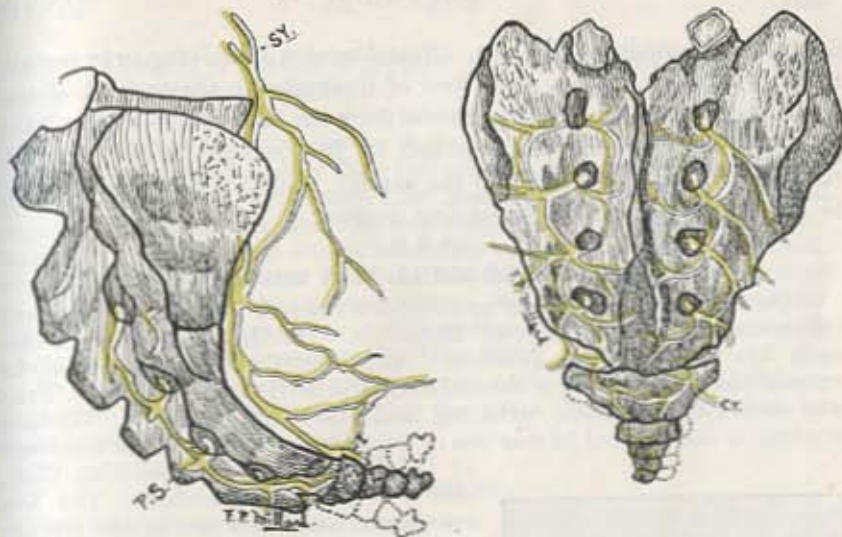


Fig. 4.—Lateral view of sacrum and coccyx, showing nerve relationship, also anterior and posterior dislocations of the coccyx. From the nerve connection shown the amount of pressure and irritation caused by a subluxated coccyx is readily understood. I. Ganglia of Iapar, in connection with the sympathetic chain (Sy). P. S. Posterior sacral nerves.

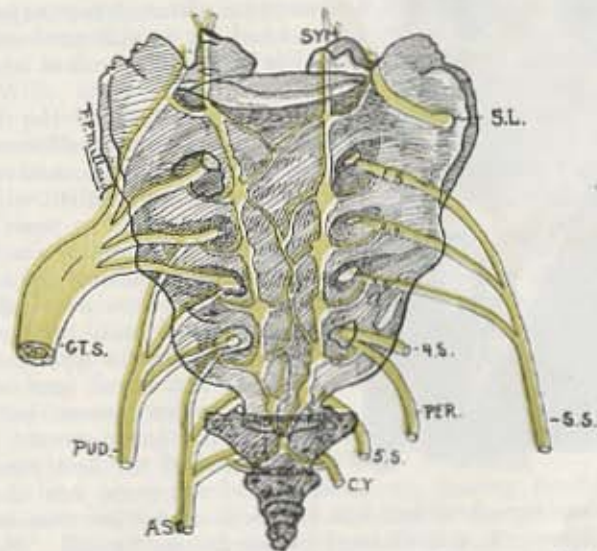


Fig. 5.—Anterior view of sacrum and coccyx, showing sympathetic nerve chain (Sym) and its connection with sacral and coccygeal nerves. Also partial formation of the Great Sciatic (G. S.) and Pudic (Pud.) nerves. Cy. Coccygeal nerve. I. S., 28, 28, 48, 58, sacral nerves. A. S. C. Anterior Sacro-Coccygeal nerve. P. E. R. Peroneal branch of the fourth sacral. P. S. Small Sciatic. I. Ganglion of Iapar. I. L. Fifth Lumbar.

ankylosis, or possibly ankylosis. Gluteal tension in walking, or in certain movements may cause a great deal of discomfort. On account of the anatomical location of the coccyx and from the fact that it is articulated at one end only the muscles attached to the coccyx affect it more readily than those attached to the sacrum, and the nerves in relation to it are affected in a corresponding degree.

* * *

A. B. FORD, NOBLE SKULL MAY 1910-JAN. 1911.

On October 25, 1883 our new Noble Skull was born on the old Ford Homestead, five miles east of Kirksville. On the farm he spent his early life in uneventful quietude. After completing public school he entered the Missouri State Normal School at Kirksville. Here Mr. Ford was active in athletics, debating and other literary work. While a student at the Normal he was one of the organizers and charter members

of the Demosthenian Debating Club, and was its first president. The Demosthenian is now one of the strongest Clubs of the school. At the Normal he was also Class President for one year, and was chosen to deliver the class oration at the graduation exercises. After graduation he taught school for two years, although not expecting to follow teaching as a life profession, as early in life he had determined upon an osteopathic career.

The members of the Ford family have all been firm believers in osteopathy for many years, and with reason, as the following incident will show:

Some twenty-five years ago one of the men of the family was struck by a falling tree, resulting in a dislocation and fracture of a cervical vertebra. Complete paralysis of the body followed. For a few weeks he was under the care of the best medical men in Kirksville and surrounding towns, but his condition steadily grew worse. Next were called some of the best medical practitioners of the state, and it was finally

decided that the condition was hopeless, and there was nothing that could be done. As a last resort it was decided to call "that old bone doctor", (A. T. Still) who, with the assistance of his brother, soon reduced the lesion. As a result the paralysis completely disappeared, and the patient has been enjoying good health ever since.

Several members of the Ford family have since then taken up the study of osteopathy, and now are engaged in its practice. Among them



is Dr. W. J. Ford, of Seattle, a brother, who is President of the King County Osteopathic Association.

Mr. Ford entered the American School of Osteopathy in September 1908, and became an Atlas man in December of the same year. He has been one of the solid men of the Club since joining, and has served on the Practical Work, Criticism, Life Membership and Constitutional Amendment Committees, and also as a member of the Investment Fund Board. He is a believer in school athletics; is especially fond of football, having played four years on the State Normal team, and has been one of the A. S. O. squad for the past two years. Mr. Ford has been President of the 1911 Class the past year and is also one of the student assistants in anatomy, acting as prosector for "Dr. Bill."

Mr. Ford is well qualified for the position of Noble Skull, and those acquainted with him are looking for the Atlas Club to advance under his leadership.


* * *

ORAL HYGIENE.

The care of the teeth and mouth is a matter which should receive much more attention than is ordinarily given to it. Children should early be taught the necessity of cleansing the mouth and teeth and after the care of the oral cavity is once made a matter of habit or routine the effort will not be noticed. As physicians and dentists well know, many diseases are contracted through the lack of asepsis in the mouth.

A national campaign on oral hygiene was opened in Cleveland, Ohio, March 18, 1910, under the auspices of a committee of the National Dental Association, and at the instance of President Taft, Passed Assistant. Surg. C. W. Wille, of the Public Health and Marine-Hospital Service, was detailed to attend the meeting in a representative capacity. In an address Doctor Wille expressed the interest of the President in the objects of the movement and commended those responsible for its inauguration.

In his report of the objects and methods of the campaign he states in part as follows:

"The efforts of the committee on oral hygiene of the National Dental Association to secure the appointment of district dental inspectors and to provide for widespread dental education on oral hygiene in the public schools of the country had their inception in 1898. Because of a lack of proper appreciation of the importance of the subject on the part of the various dental and medical societies, boards of health and education, the movement lagged, and it was not until two or three years later that a few pages on the physiology of the teeth were inserted in some of the text-books on this subject. 

Russia was the pioneer in this movement, having established a system of inspection of the teeth of the children in the public schools, as early as 1879. Since then Germany, Great Britain, France, Belgium, Holland, Denmark, Italy, Japan, and New South Wales have instituted similar inspection.

In this country the State of Massachusetts has taken cognizance of the importance of this work, so that at present popular lectures on dental hygiene and prophylaxis are permitted in some of the public schools

under the supervision of the respective boards of public education. At this time the city of New York maintains clinics for the care of the teeth of the children of the indigent poor. The city of Rochester maintains one clinic. Some of the cities of New Jersey, Indiana, Illinois, Mississippi, Iowa, Minnesota, Georgia, and Washington have instituted dental examinations to date."

At the convention of the National Dental Association held two years ago one session was devoted to the subject of oral hygiene, at which, on account of the enthusiasm of its delegation, the city of Cleveland was selected as the headquarters of the national committee on oral hygiene. By persistent effort this committee obtained a hearing before the Cleveland board of education, as a result of which permission was granted to make dental examinations in 4 of its public schools.

This examination of 2,677 pupils was conducted by members of the local dental society under the supervision of the chairman of the committee on oral hygiene of the National Dental Association, disclosing the fact that 97 per cent of the children gave evidences of dental and oral diseases.

No doubt a similar percentage of children affected with oral disorders would be found upon examination in almost any community, and the movement to have inspection made is a step in the right direction.

* * *

THE DEADLY HOUSE FLY.

"No respectable woman will allow flies in her home any more than she would permit other vermin" reads a street car placard in New Orleans.

All too slowly is the general public becoming educated to the deadly character of the common house fly. Each year sees more in the public press concerning this dangerous pest, and perhaps the view is not too sanguine that within the next decade there may be waged an organized exterminating war on this hitherto unrecognized peril.

The Ladies' Home Journal of August '09 contains an article on this subject with statistics which should be read and given thought by every physician in the country. A portion of the article follows:

"That flies do carry disease germs is readily proved in the laboratory. The microscope shows that the leg of the fly is covered with stiff bristles like a head of ripened wheat. The foot ends in a pair of pincers. The mouth and head are rough. When you thrust a stiff-bristled broom into a dirt-heap you do just what the fly does when he alights on the refuse-pile. When you lift your broom some of the dirt comes with it. When the fly leaves some of the filth sticks to him. When you set your broom down you shake off some of the dirt. And when the fly walks about he leaves behind him a trail of filth.

The number of germs that a single fly can carry is almost beyond belief. Dr. William H. Park, chief bacteriologist in the Department of Health Research Laboratories, let a fly walk about in a culture of typhoid fever germs, then transferred him to a gelatine plate. In the trail left by that fly in the gelatine were 30,000 bacteria. At the agricultural station at Storrs, Connecticut, were examined four hundred and fourteen flies. The aim was to discover, not how many bacteria a fly would drop

as he walked, but how many he carried with him. Flies were put into bottles of sterilized water and shaken thus washing off all the bacteria. Several others had 6,600,000. The average for the four hundred and fourteen flies was 1,222,570. And a very few bacteria will often cause death!

The entire tale of deaths caused by flies can, of course, never be known. We have, however, the record of deaths from diarrhoeal diseases and typhoid and the figures are truly appalling. When we remember that flies are known to transmit not only typhoid fever and diarrhoeal diseases, but also tuberculosis, and probably influenza, pneumonia, diphtheria, scarlet fever and other virulent diseases, we can only guess at the terrible havoc wrought by the house fly.

"It has been for some time thoroughly well demonstrated, that the fly is one of the chief agencies in the spread of Asiatic cholera. Hitherto the fly has been regarded complacently as a harmless nuisance, and considered to be an annoying creature with great persistence and excessive familiarity. Regarded in the light of recent knowledge, the fly is more dangerous than the tiger or the cobra. Worse than that, he is, at least in our climate, much more to be feared than the mosquito, and he may easily be classed the world over as the most dangerous animal on earth." says Daniel D. Jackson, one of New York City's bacteriologists.

The term "the world over" expresses exactly the range of the fly problem. The fly is not confined to New York City. Wherever there are open sewers, or garbage-piles, or heaps of manure, or stacks of oyster shells, or exposed human excreta, or festering corpses of animals, or mouldering paper, or decaying vegetables—in short, wherever there is filth the fly exists; for the fly breeds in filth.

The solution of the problem is, of course, to exterminate the fly. That sounds like a big task. Perhaps it is. So it is a big task to exterminate the mosquito. Yet when we found that the mosquito was our enemy we made warfare upon him. The yellow-fever-bearing *stegomyia* has been subdued. The less harmful malaria-carrying *anophele* is destined to meet the same fate. The State of New Jersey is spending thousands of dollars to drain her marshes. Other states are following her example. In the same way, when we come to a realization of the character of the fly some systematic plan of campaign against him will be devised. Already Philadelphia, Seattle, Chicago and other cities, and the states of Louisiana and Florida, are carrying on a vigorous warfare against the fly.

It will be a long time, however, before the country is fully awake to the danger, and a longer time before the fly is subdued. Meantime, because of flies, babies are dying—perhaps yours among them. There is work for you to do, for the fight against flies, like charity, should begin at home. Cleanliness is the watchword of this fight against flies. It is in filth that flies breed. It is from filth that they pick up the germs that they scatter broadcast. You will recall the flies examined at the Connecticut agricultural station. The one that had only 55 bacteria on it was caught in the laboratory, where everything was clean. The flies with the 6,600,000 bacteria came from a swill-barrel. Keep your home clean, your yard clean, your neighborhood clean, your city clean. Per-

haps you think that, because flies travel only short distances, it is a matter of no importance to you whether a part of the city two miles away is clean or not. It is important. Flies get into cars and wagons and on horses and are carried miles. The garbage-pile two miles away may be just as harmful to your babies as though it were in your back yard.

But it is in the home that most care should be exercised. It is there that we contract disease by eating infected food. You will recall how the fly that walked on the gelatine plate left behind it 30,000 bacteria. That is what happens when a fly crawls over your meat, or alights on your bread, or buzzes in your sugar-bowl. He leaves behind him the seeds of death. You will recall also how the flies that were washed clean in the bottles of water were found to have been swarming with millions of bacteria. Something very similar to this washing process happens when a fly falls into your milk. He struggles to get out, and he leaves behind him, not a few thousand bacteria dropped from his feet, but all the bacteria he had on his body. Those bacteria on the meat will not increase much, but the bacteria in the milk will grow like mushrooms. In a few hours your baby's milk may be no longer milk. It may be liquid typhoid fever. And those flies that are buzzing around your baby's nose as he sleeps so innocently and trustingly may just have come from feasting on a consumptive's sputum. They may leave a trail of tuberculosis germs on your baby's lips that your little one, ignorant of danger, will draw into his system with his next breath. You know the fly now. Keep him out of your house. Keep him away from your food. Keep him away from your baby. Fear him as you would death—for the fly is death."

The Iowa State Board of Health last season issued a bulletin on this important subject, and while brief, it is to the point, and should have a wide circulation:

"The house-fly breeds during the warm months of the year, in the filth of the barnyard, in the manure of the stable, in the decaying garbage at the kitchen door.

He feeds on the filth from all these places, on the spit of the consumptive, on the festering wounds of men and beasts, on the bodies of dead animals.

He carries the filth from everything he touches, and may be covered with millions of death-producing germs. He may carry the dread germs of typhoid fever or the germs of consumption.

He flies from the barnyard to the clean dishes of vegetables on the dining table; from the spit of the consumptive to the nipple of the baby's bottle; from the garbage can to the lips of the sleeping child; from the dead body to the fresh fruit.

Screen your doors and windows.

Cover the dishes and keep them covered.

Store the manure where the flies cannot reach it, and remove it frequently.

Put your garbage into cans, and keep the cans tightly closed.

Prevent the flies from breeding by allowing no filth or dirt to accumulate around the house, the stable, the barn or the yard.

Pour kerosene oil into the drains and kill the eggs of the fly.

Where there is no dirt or filth there will be no flies.

Beware of the fly!"—Iowa Health Bulletin.

TOO MANY DOCTORS.

According to Charlie Miller in the Des Moines, (Ia.) Capital of April 9th. the A.M.A. is trying to close the Western Medical Schools, those in Iowa affected being Medical Department of Drake University at Des Moines and the Medical Department of the Iowa State University.

—Primarily, the desire to put Drake and other western medical schools out of business is to relieve the pressure from a profession that is much overcrowded. A recent enumeration showed that there is in this country one M. D. for each 527 people, and with osteopathy, chiropractic and other various systems of drugless healing constantly gaining favor, it is plain to be seen that there is not enough practice to afford a decent living to all of this horde of M. D.'s unless something is done about it.

The American Medical Association is trying to improve conditions for its adherents in three different ways, viz.: By encouraging local associations of doctors, who double the size of their fees; by reducing the annual output of medical graduates, and by promoting a federal health department, that would take several thousand doctors out of active practice and put them on the government pay roll, there to participate in the division of the millions upon millions of dollars that Irvin J. Fisher, the chief promoter of the proposed federal health department says will be put into what he so naively terms, 'a needed form of national defense.'

"Since the 'Doctors' trust,' like all other trusts of national character, is dominated by eastern men, the west is made to suffer in the attempted reduction of the number of medical schools. Of course, Drake could tell the American Medical Association to go to the devil, but that would result in its faculty, as well as its students, being subjected to a boycott on account of being 'irregular'. Even medical students in their first year, realize that a diploma issued from a medical college under the ban of the American Medical Association would have little value under the present conditions of Cannonism in medicine, and it is assumed that Drake will have to comply with the almost impossible conditions imposed or shut up shop. Those are the only two alternatives being considered at least; but I would suggest that there is another way, and that is, to raise aloft a banner of medical independence and invite all other western colleges to take a stand with them under it. This is an age of insurgency, and there is no place where insurgency carried to a successful end could confer such great blessings as in the realm of medicine."

* * *

SOIL POLLUTION BY THE SURFACE PRIVY.

Dr. Ch. Wardell Stiles, writing recently on the above subject, said:

"Recent investigations have brought to light certain conditions of soil pollution which call for serious consideration because of their influence on the spread of disease, especially hookworm disease and typhoid fever.

By actual count of 366 farmhouses scattered over four Southern States, it was found that only 115 houses, or 31.4 per cent, were provided with privies, while 251 houses, or 68.5 per cent, had no privy. Thus, a condition of theoretical maximum soil pollution was occurring around 68.5 per cent of the houses in question. When it is considered that both hookworm disease and typhoid fever are spread through night soil, the importance of this soil pollution becomes evident.

Even when a privy is present soil pollution may occur in case the outhouse is not properly built or not properly cleaned.

It should be recalled that anything less than a sewer system is a compromise with the ideal, and when from financial or other reasons a sewer system is not feasible, it is well to make the best possible compromise.

Among several thousand privies examined, on farms and in various villages, the prevailing style was found to be the surface privy open in back. This is the poorest compromise that can be made, for not only is the danger present of contaminating the water supply in near-by wells, but soil pollution naturally occurs around the outhouse, and this is increased by the fact that chickens, dogs, and hogs have access to the night soil and scatter the infectious material around. Further, also, flies and other insects either breed in or feed upon the excreta and carry fecal material to the food in the houses. An urgent necessity is present for a radical reform in this matter and for the abolition of this style of privy.

A slight but not sufficient improvement is found when this style of privy is provided with a swinging door in back, thus not only improving the appearance of the structure but excluding chickens, dogs, and swine from the excreta.

A still further improvement is obtained by use of a floor privy, with a water-tight tub under the seat; the back should be closed by a swinging door. Every time this tub is emptied a thin layer of sand or other soil should be placed in the tub. If a cheap fluid disinfectant also is placed in the tub this will tend not only to kill the disease germs but also to repel the flies and other insects, to decrease the odor, and thus to render the privy less of a nuisance than it otherwise may be, especially in warm climates and in summer.

Still another style is found completely closed in back, and a pail is placed under the seat. This pail is taken out through the front.

In only a comparatively few instances were water-tight vaults found. The vault has, of course, certain great advantages, but is somewhat more expensive than the tub and pail systems and is also not so easily cleaned by the house occupants. Even when a vault is present it is advisable to use some insect repellent. In some instances it was found that when the privies were cleaned the night soil was used for fertilizer. Without going into the question whether or not the value of human excreta as fertilizer is as great as popularly supposed, attention may be invited to the important fact that especially in any warm and moist locality, particularly in sandy regions, such use is a menace to public health unless the night soil is stored for some time in order to permit it to thoroughly ferment. With the present knowledge of the methods by which typhoid fever is spread, the sale of fresh untreated night soil by towns to farmers, for use as fertilizer, is without excuse and should be prohibited.

One method of disposal of the excreta taken from the privies is to burn it. This method is almost ideal, but naturally involves some expense; nevertheless, it is worth the expense. In case the fresh night soil is buried, care should be taken to bury it in a place sufficiently

removed from any drinking-water supply to prevent infection.

A reduction of soil pollution means a reduction of hookworm disease and typhoid, hence a reduction of the mortality, especially in women and children, an increase in vitality and mentality, and an elevation of conditions mental, physical and financial."

Soil pollution is a matter of grave importance, far more so than the average individual thinks, if he thinks of it at all—and physicians should use their influence and urge the establishment of sanitary surroundings at the homes of their patients.

MILK AND ITS RELATION TO PUBLIC HEALTH.

In 1908 the Public Health and Marine-Hospital Service issued a 758-page bulletin entitled, "Milk and Its Relation to the Public Health," containing chapters on the following subjects:

1. Introduction.
2. Milk as a cause of epidemics of typhoid fever, scarlet fever, and diphtheria.
3. The Milk supply of cities in relation to the epidemiology of typhoid fever.
4. Frequency of tubercle bacilli in the market milk of Washington, D. C.
5. The relation of goat's milk to the spread of Malta fever.
6. Milk sickness.
7. Relation of cow's milk to the zoo-parasitic diseases of man.
8. Morbidity and mortality statistics as influenced by milk.
9. Ice cream.
10. The chemistry of milk.
11. The number of bacteria in milk and the value of bacterial counts.
12. The germicidal properties of milk.
13. The significance of leucocytes and streptococci in milk.
14. Conditions and diseases of the cow injuriously affecting the milk.
15. Sanitary inspection and its bearing on clean milk.
16. Sanitary water supplies for dairy farms.
17. Methods and results of the examination of water supplies of dairies applying the District of Columbia.
18. The classification of market milk.
19. Certified milk and infants' milk depots.
20. Pasteurization.
21. Infant feeding.
22. The municipal regulation of the milk supply of the District of Columbia.

The demand for the publication was so great that the edition was quickly exhausted and a second edition was made necessary. In the later edition some slight revision was made in order to include certain work which had been done after the original publication came out, and in addition, chapters with the following titles were added:

- The Relation of the Tuberculosis Cow to Public Health.
- The Thermal Death Points of Pathogenic Micro-organisms in Milk.
- The Relative Proportion of Bacteria in Top Milk (Cream Layer) and Bot Milk (Skim Milk) and its Bearing on Infant Feeding.
- National Inspection of Milk.

The new edition is now available and health officers who did not receive copies of the first can secure copies of the second edition by writing to the Surgeon-General, Public Health and Marine-Hospital Service, Washington, D. C.; others desiring the bulletin can obtain it from the Superintendent of Documents, Government Printing Office, Washington, D. C.; at the cost of \$1 a copy.

NEW JERSEY BILL.

New Jersey has been the seat of much controversy this winter in the way of legislation concerning osteopathy.

As the osteopathic publications have contained full accounts of the provisions of Assembly Bill No. 156, over which the controversy has existed we will not publish them.

Suffice it to say that the bill was a virtual shut out for osteopaths in New Jersey and while it passed both houses of the legislature it went down under the Governor's veto.

Gov. Fort of New Jersey is favorable to osteopathy—in fact his medical physician on one or two occasions sent him to an osteopath for treatment.

To be sure that his views in the matter of the bill would be unbiased Gov. Fort called in the Attorney-General and asked him to hear the arguments on the bill pro and con with him.

During the arguments, which were quite heated, Gov. Fort lost his temper and passed the lie to Dr. Luther M. Halsey, Chairman of the Legislation Committee of the State Medical Society.

At the Governor's request Attorney General Wilson prepared a written opinion on the merits of the bill, from which we quote the following:

"That the practice of osteopathy should be regulated is agreed.

From the point of view of the public, those who shall receive treatment under the osteopathic school must be safeguarded by regulations designed to sustain and uphold competency and skill. The physicians of all recognized schools should be protected against competition from those who are not qualified properly to treat the illness of the public at large.

The reputable osteopath should be protected particularly from the discredit which attaches to any profession in the hands of those who are neither qualified to practice within such profession under its proper name, or who refuse to regard either the proper limits of such practice or the ethics applicable thereto. But I do not believe that any such necessity warrants an injustice to osteopathic physicians who are qualified to practice their profession.

Where the application shall be for a license to practice osteopathy the applicant must, in addition to the proofs of preliminary education, produce evidence that he or she has received a diploma conferring the degree of doctor of osteopathy from some legally incorporated osteopathic college, and has also studied osteopathy for not less than three full school years of at least nine months each, including three satisfactory courses of lectures of at least seven months each in three different calendar years in some legally incorporated American or foreign osteopathic college prior to the granting of said diploma or foreign license.

Limitations Too Arbitrary.

With particular reference to that part of the provisions stated, which applies to the requirement for license as an osteopathic physician, the requirements are open to possible objection upon the requirement of three full school years of at least nine months each, including three satisfactory courses of lectures of at least seven months each.

I am not advised as to the duration of the school years or the courses of lectures in the various osteopathic colleges, but the limitation of nine months as a definition of a full school year, and seven months as the duration of a course of lectures while possibly conducive to proficiency, may, as inflexible limitations, exclude the graduates of schools or colleges whose terms and courses may, for any reason, fall ever so slightly within these limits. To the requirements of examination of applicants subsequently to July 4, 1912, this objection also applies.

It may be contended that the provisions of section nine answer the objections previously stated, with reference to the sweeping application of those now engaged in the practice of osteopathy in this State, the provisions of this section being that any person now a legal resident of this State and actively engaged in the practice of osteopathy prior to the passage of this act, who shall make application for a license within sixty days after the passage of this act, and exhibit a diploma or certificate of attendance from a legally incorporated school or college of osteopathy, showing that the holder thereof had completed a course of not less than four terms of five months each of actual attendance, with proof as to the personality, a license shall be issued without examination, granting the right to practice osteopathy, with the limitation that such license shall not authorize the holder thereof to prescribe, administer or give any drug or medicine, serum, anti-toxin or vaccine, practice surgery, attend any infectious, contagious or reportable diseases, or sign any birth or death certificate.

The limitations upon this section seem to me to make the license so obtained practically valueless to anyone who will literally and specifically adhere to the regulations under which such license is to be granted. I do not know what osteopathic schools or colleges would be included or excluded under the requirements of a course "not less than four terms of five months each," nor whether this would or would not be a fair and proper requirement. Under this limitation no person so licensed could administer a stimulant to a patient needing immediate stimulation, even though at the time being treated for some ailment which lay within the proper limits of the practitioner's authority, nor could an osteopathic physician treating a patient for a simple cold advise such patient to use any drug whatever in connection with such treatment, should he desire to do so.

Prejudice Seems Apparent.

It may be possible that the osteopathic physician should not be permitted to sign a birth or death certificate, although a midwife may sign the first, but that he should not be allowed to prescribe any drug or medicine whatever, use any serum, antitoxin or vaccine, practice the simplest surgery, attend any infectious, contagious or reportable disease of whatever character, seems to me not to be in the nature of a safe and proper limitation upon osteopathic practice, but to be grounded at least to some extent, in prejudice and to make regulation a means of injustice not only to the osteopathic school, but possibly as well to the public at large.

Moreover, it would seem that the bill creates two distinct classes of osteopathic practitioners. First, those who are permitted to practice upon presentation of cer-

tificate and without examination before the first day of August, 1910, and second, those who submit themselves for examination in due course.

The first group of practitioners, by the terms of the act, are not permitted to sign birth or death certificates, nor are they allowed to prescribe any drug, use any serum, etc., practice the simplest surgery, or attend infectious, contagious or reportable diseases.

The second group, constituted of those licensed under this act, after examination, will be authorized to practise medicine and surgery in all branches as fully as any other physicians, yet under the provisions of the act those licensed after examination, may style themselves doctors of osteopathy, and may hold themselves out as such in the community where they seek to practice without any differentiation apparent to the public as to the limit or extent of their powers.

Not only is such a method of classification unsafe and confusing, but, it seems to me, of questionable legality. Some provision should have been inserted in the act by which the general public might be advised as to the extent of the authority and powers of the two classes of osteopathic doctors constituted under the act."

THE BULLETIN

OF THE ATLAS AND AXIS CLUBS.

IRVIN FISH CRAIG, EDITOR.

M. A. BOYES, BUSINESS MANAGER.

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Copies lost through change of address without notification can generally be furnished by the editor at ten cents per copy.

KIRKSVILLE, MISSOURI, MAY, 1910.



New Editor. With this issue the present editor retires, and next year THE BULLETIN will be issued under the direction of Mr. Ernest R. Humphries.

We have used our best endeavors to make THE BULLETIN a paper worthy of the Atlas Club and Osteopathy. We have learned much, and in the light of our past experience see where we might have done better.

To those of our Club who have so earnestly supported THE BULLETIN we extend our thanks. Especially do we wish to mention our co-worker, Mr. M. A. Boyes, who has not only been a faithful and devoted worker for the advancement of THE BULLETIN, but is also a worker for the advancement of the Atlas Club as well. Mr. Boyes is an able man, and we are sorry that he felt compelled to resign the position to which he was re-elected.

To the editor-elect we wish the utmost success. He comes from Malden, Mass., and is a graduate of Tuft's College, Boston, with the A. B. degree. Mr. Humphries is a nephew of Dr. Alfred and Effie L. Rogers of Boston. Previous to taking up the study of osteopathy in the Massachusetts College he had two years experience on various Boston newspapers.

Mr. Humphries is well qualified for the duties he is to undertake, and we look for the steady advancement of THE BULLETIN under his management.

Do you Want One? Much favorable comment has been made concerning the leading articles which have appeared in THE BULLETIN the past year on osteopathic practice, and many have expressed a desire to have them and the balance of the series in book form. In fact the demand became so insistent that we finally said to our friends that if they could interest enough people in the publication to make it a financial success that we would compile from our shorthand notes a volume on the osteopathic treatment of disease and one which we believe will be far superior to anything of the kind in osteopathic literature. The articles would be similar in style and make-up to those which have appeared in THE BULLETIN this year on Diphtheria, Measles, Pneumonia, Scarlet Fever, Typhoid Fever, and Tuberculosis.

We would want to make the subject matter as concise as possible, at the same time not sacrificing clearness to brevity. With this idea carried out, we contemplate a book containing somewhere between 400 and 600 pages, printed on good quality of book paper, cloth bound, with stiff covers, and having what is almost as important as a good book—a concise, and accurate index. The book will be put out in good shape if published at all.

The price, of course, will depend very much on the size of the edition we are able to put out, as well as on the number of pages contained. In any event it will not exceed five dollars, and if you have read THE BULLETIN this year you will realize at once that it will be worth many times the price.

Whether the volume appears or not depends upon how many wish to have it. We have said to our friends that if they will place orders for 250 copies in advance we will go ahead, and try to have the book out sometime this fall. About half of this number have already been placed. We are not in the book business, and expect to publish only such number as our advance orders warrant.

If you are interested in such a book, and are willing to subscribe five dollars for it (the maximum possible cost) payment to be made when book is ready for delivery, signify it at once, to Irvin Fish Craig, General Delivery, St. Paul, Minn.

* * *

Atlas and Axis Reunion. Do not forget the meeting of the A. O. A. at San Francisco in August.

There will be an Atlas and Axis reunion, as well as much to hear and see at the Convention. Then, it comes at a time when you need a rest. So try to be there.

* * *

Innovation With this number of THE BULLETIN we are making an innovation in the matter of illustration, and present some of Dr. Frank P. Millard's best work in colors, accompanying his article on Coccygeal Lesions. Dr. Millard is an Atlas man and is proud of it. We are proud of him.

Avalon and Santa Catalina Island

On page 400 of the April BULLETIN appeared a cut, which, through oversight, was printed without explanation. The cut was of Avalon, on the Island of Santa Catalina, distant from San Pedro three hours of safe and unusually pleasant steaming.

This is crystallized fairyland; the placid and translucent waters teem with every form of marine algae and piscine life. Here, if anywhere on earth, is the place to acquire the reputation of successful angler. Atmospheric and terra firma attractions are in harmony with the ocean's profusion.

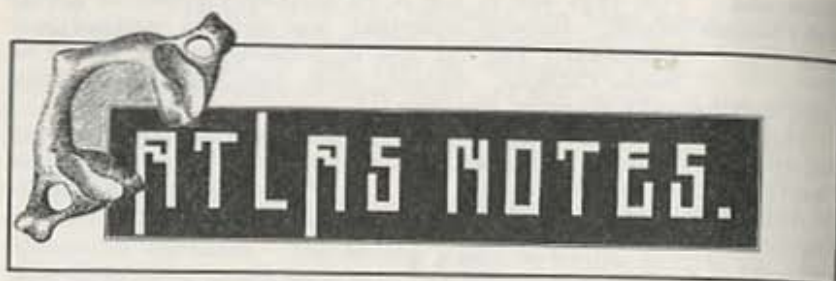
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The Medical Trust.

We have from the publisher this month a booklet "The Doctor's Trust, A Story of Medical Greed Run to Madness" by Charles W. Miller, of Waverly, Iowa.

These articles appeared originally in the National Magazine last year and attracted widespread attention throughout the country.

Mr. Miller is a member of the Iowa Legislature from Bremer County and has been bitterly opposed to the greed of the doctors. He is not opposed to the profession as such, but stands for the rights of the people. Mr. Miller tersely says that in Bremer County no one with \$200 and a stomachache is safe over night. His booklet is well worth the reading and we trust will have a large sale. It may be had directly from the publisher at 25 cents per copy discounts in quantities.



F. M. Plummer, Dr. R. H. Prindle, Dr. E. Purnell, Dr. M. L. Ray, Dr. W. L. Rogers, Dr. G. W. Riley, Dr. S. E. Russell, Dr. H. L. Russell, Dr. Alice Patterson Shibley, Dr. G. H. Smallwood, Dr. Alice M. Spence, Dr. T. H. Spence, Dr. B. F. Still, Dr. C. E. Still, Dr. A. K. Stryker, Dr. K. Talmadge, Dr. C. C. Teall, Dr. E. K. Traver, Dr. E. Tracey, Dr. E. K. Underwood, Dr. H. M. Vastine, Dr. H. L. Van Deusen, Dr. O. M. Walker, Dr. Richard Wanless.

Dr. Leonard Tabor ('09) of Silver City, N. M. writes this month concerning the New Mexico State Board examination. It was held at Santa Fe on April 4th, the osteopaths taking it and passing being Wm. Hubbard, B. F. Schmentker, Walter Mayes ('09) and Dr. Tabor.

"The Board treated us right well" said Dr. Tabor. "The exam could not have been fairer, and we were all well pleased. It has been told so often that the Board here "soaks 'em" that it gives me pleasure to say there is nothing to it now, whatever it may have been in the past. Tell the Club boys for me that any of them desiring to come here will be given a square deal I am sure. I am told that there are some good openings in Eastern New Mexico, but I do not know of any myself that I would recommend very strongly. The towns are not very large, and have a large percentage of Mexicans, who are very undesirable, I find. Osteopathy is not very well known in general, and M. D.'s are as thick as they can stick. Las Cruces is a town of about 4000, three-fifths Mexican, has no D. O. but 13 M. D.'s. Aside from those two drawbacks it is a good town. The Board here has discontinued issuing temporary licenses on an opinion of the Attorney General which declares against it. Examinations are held April and September, fee \$35, no reciprocity."

Brother M. J. Grieves ('09) of Peoria, Ill., has been heard from. In a letter to the Plyorus he says: "I miss the Club a whole lot, but enjoy THE BULLETIN more than I can express. I am glad the Club is getting along so well. I know THE BULLETIN has improved a whole lot. I am getting along fine in Peoria and have gotten fine results. Osteopathy can sure do the work. I hope to visit the Club rooms sometime soon if I come the last of May for commencement. Am anxious to see all the fellows again."

Dr. Wilden P. Snare ('07) of Denver writes this month: "After three years am becoming more and more enthusiastic in my conviction that Osteopathy is head and shoulders ahead of any other school of healing in existence."

Dr. Snare has qualified as a nerve specialist since leaving the A. S. O. and says he has met with good success. He and Dr. A. S. Loving have have lately formed a co-partnership with offices in the Temple Court Bldg.

In a letter to the Club this month Dr. N. D. Wilson, of Manchester Iowa, says:

"If the Club is as good as THE BULLETIN you fellows are in position to get a lot of mighty valuable knowledge. Osteopathy is all right and results will be gotten. If the general public only knew more anatomy and physiology, an osteopath would be the busiest person on earth."

New Officers. The semi-annual election of the Club was held at Atlas Hall the night of May 7th with the following results:

Noble Skull, A. B. Ford;
Occipital, F. E. Magee;
Stylus, F. S. McGonigle;
Receptaculum, Thomas L. McBeath;
Editor of THE BULLETIN, Ernest R. Humphries;
Business Manager, BULLETIN, M. A. Boyes;
Trustees: Dr. C. E. Still, Dr. F. P. Pratt, A. B. Caine;
Investment Board: Dr. A. G. Hildreth, St. Louis- Dr. E. C. Link, Elizabeth N. J.; Dr. R. E. Hamilton, Kirksville; E. S. Mitterling, 1911; K. B. Phillips, 1911.

Since our last issue Life Membership Certificates have been issued to Doctors J. H. Roebuck, of Trinidad, Colo; Chas. E. Banker, Kingston, N. Y.; Ernest Sisson, Oakland, Calif.; Geo. E. Horn, Haverhill, Mass.; Asa Willard, Missoula, Montana. This makes a total, at the close of April, of 50 certificates issued since the plan went into effect.

An osteopathic event of more than passing moment occurred in New York the night of March 26th at the Knickerbocker Hotel when Dr. Carl P. McConnell (Atlas '96) addressed an audience of some 800 osteopathic physicians and prominent men, on the results of his osteopathic research, following which a banquet was served.

Besides Dr. McConnell, some of the prominent speakers of the evening were Mr. S. S. McClure of McClure's Magazine, Mr. Turnbull White of Everybody's Magazine, Mr. Joe Mitchell Chapple, of the National Magazine; Hon. Martin W. Littlejohn of New York City; Mr. Alexander Black of the Sunday World; Hon. Geo. H. Shibley, of Washington; Mr. Herbert N. Casson and Mr. Arthur Brisbane, the latter being editor-in-chief of the Hearst Newspapers.

In a list of the banqueters we notice a large percentage of Atlas and Axis Club members among whom may be mentioned: Dr. Maude F. Barger, Dr. A. S. Bean, Dr. T. D. Berry, Dr. E. M. Casey, Dr. M. K. Cottrell, Dr. J. E. DeTienne, Dr. W. E. Dillabough, Dr. Franklin Fiske, Dr. F. L. Goehring, Dr. L. M. Goodrich, Dr. C. G. Hatch, Dr. Hawes, Dr. Chas. Hazzard, Dr. E. B. Hart, Dr. Mary V. D. Hart, Dr. G. A. Haswell, Dr. A. S. Henry, Dr. E. Howard, Dr. C. M. T. Hulett, Dr. G. W. Krohn, Dr. E. C. Link, Dr. H. B. Martin, Dr. D. N. Morrison, Dr. C. B. Morrow, Dr. E. L. Myers, Dr. H. A. McMains, Dr. R. Nicholas, Dr. T. H. O'Neil, Dr.



Since the last issue of THE BULLETIN the following candidates have been initiated:

Mr. J. Marshall Phillips, of the 1911 class was formerly Assistant Paymaster of the A. S. & T. P. Co. at New Castle, Pa. Mr. Phillips says that being physically disabled he was recommended to go to an osteopath, though he had been taking treatment from an M. D. for one year previous to this time. "Scientific studies were of interest to me at this time and osteopathy as told to me by the practitioner appealed to me immediately, my interest in the latter being augmented by a rapid recovery." Mr. Phillips possesses a High School diploma.

Richard Sullivan was formerly a railroad station agent at Washta, Iowa. He became interested in Osteopathy through the influence of a graduate nurse and Dr. Charles Johnson, of Schuyler, Neb. He accordingly came to Kirksville to take up the study.

Mr. A. Orville Waller is a son of Dr. Olive C. Waller of Eugene Oregon. Mr. Waller was formerly engaged in civil engineering, but through his mother's influence he became interested in Osteopathy and he accordingly came to Kirksville. He is a High School graduate and spent two years also in at the University of Oregon.

Mr. Claude J. Crain was formerly a railroad man at Brookfield, Mo., but became interested in osteopathy through Dr. W. J. Deeming of that place and decided to take up the study.

Mr. O. P. Ahlquist formerly practiced massage and Swedish movement at New Castle, Pa. Having read about osteopathy he became interested and finally concluded to take up the study at Kirksville.

Henry Griggs was formerly in the drug business at Harper, Kansas, but having been relieved of asthma through osteopathic treatment, decided to take up its study at Kirksville.

Lewis Griggs Robb, is from Enid, Okla. He was formerly in the U. S. Navy but observation of the results of osteopathic treatment, in cases where other systems failed decided him on an osteopathic course at the A. S. O.

Harvey L. Landis was a clerk and stenographer in the employ of the Pennsylvania Railroad Co., at Harrisburg, Penn. He became acquainted with Dr. Harry M. Vastine of that place, and noting the Doctor's success decided on osteopathy as a profession. He is a member of the June 1912 Class.



At the semi-annual election of officers of the Axis Club, the following were chosen for the next semester:

- President, Mrs. Christine Irwin;
- 1st Vice-President, Mrs. Lucy M. Hull;
- 2nd Vice-President, Mrs. Jennie K. Beckler;
- Financial Secretary, Miss S. L. Balfe;
- Recording Secretary, Miss M. G. Crossman;
- Corresponding Secretary, Mrs. Ruth McBeath;
- Treasurer, Mrs. M. L. Payne;
- Janus, Miss Jennie M. Chase;
- Librarian, Miss Emily Malcolmson; Editor, Miss Ethel D. Roop.

Dr. Annie McCaslin writes that she has removed to 908 Center St., Wilkinsburg, Pa., but that she will still have a branch office in New Castle, Penn.

Dr. Mary Matthews Ewing, Helena, Montana, sends congratulations to those upon whom the Degree of D. O. is about to be conferred and says in part, "I am doing so much better than I ever dreamed I could Am getting gratifying results and am establishing a good name for my self and my profession. I never let an opportunity pass to speak a good word for an Axis woman." This is the kind of loyalty every member should have for her Axis sisters.

Dr. Martha A. Morrison, whose name was omitted in the Directory writes that her address is 1021 11th Street, Greeley, Colorado.

Dr. Edmire M. C. Casey, Binghamton, New York, sends good wishes for health and prosperity to all Axis sisters. She says "Our practice here is very satisfactory but my part of it, since the arrival of baby, has been a small one. Am getting back into the work gradually though and it seems good."

Dr. Lulu F. McManis, Baird, Texas, sends greetings to club members.

Dr. Sarah E. McRoberts, Pittsburgh, writes "To those of you who will be joining us in the field before many days, I bid you a hearty welcome and may abundant success crown your efforts."

Dr. Ella Bissell Plummer, 50 Cleveland St., Orange, N. J. sends good wishes to the Club.

A very interesting letter was read recently at the club from Dr. Nora B. Pherigo, Fulton, Kentucky, in which she gives some good sound advice to those about to go out into the field. She says that the first two and a half months she was there she took in \$4.00 while now, in less than a year she is unable to handle her practice alone but has an assistant. "One reason for my success is that I've had a number of acute cases considered beyond help by the medical physicians and brought them through with osteopathy. Do you wonder therefore, that I have no desire for an M. D. degree and that when I hear any one advocating it I lose confidence in his ability as an osteopath? Every day I am more enthused about our wonderful science and feel like exclaiming "God bless Dr. Still."

* * *

Wednesday evening April 20th, Dr. A. Lotham Conger, of Akron, Ohio visited the local chapter and gave us a very entertaining and helpful talk. Friday evening April 22nd, an informal reception was held for Dr. Conger and the members persuaded her to tell us many of her interesting and varied experiences. The Doctor said if there was one thing more than another she wished us to remember it was this "You are sure to win." The Doctor's talk was a treat for every member and we hope she will come back again soon to Kirksville for another visit.

* * *

Many of the members of the Class of 1910 who leave us so soon have as yet not decided where they will go, but we give below a partial list of their locations.

Mrs. Eva M. Craig, Portland, Oregon. Miss Albertina M. Gross, Joliet, Ill. Mrs. Lydia H. Holmes, Pekin, Ill. Miss Lulu Hubbard, Artesia, New Mexico. Mrs. V. R. Murphy, 2728 Ingrain Block, Eau Claire, Wis. The Misses Sears, Oregon. Miss Lily F. Taylor, Stillwater, Minn. Miss Maude L. Warner, Cincinnati, Ohio. Miss Grace Wilson, Grand Junction, Colo.

Miss Margaret L. Loring has not decided where she will locate permanently but expects to take the practice of Dr. Noyes, of Ottawa, Ill., while the Doctor is abroad. Mrs. Ida M. Rogers expects to spend the summer in Delta, Colo., but does not know where she will locate.

Dr. Mary Perret, who has been doing P. G. work expects to return to Washington.

Dr. Della K. Stevens and Dr. Clara E. Morrow, Post Graduates, have both left Kirksville. Dr. Stevens has taken the practice of Dr. McK'y of Muskegee, Oklahoma while Dr. McK'y takes a rest and Dr. Morrow has returned to Butler, Pa., to practice with her husband.

* * *

Dr. Eva Mains Carlow of Medford Oregon, sends kind regards to the Axis girls.

* * *

Dr. Elva J. Lyman, Madison, Wis., asks to be remembered to those she knows in the Club and school.

* * *

Dr. Annie E. Bell-Hilliard writes of her change of address to Haileyburg, Ont., Canada and sends greetings to the Club members.

As we mentioned in THE BULLETIN last month, the Editor has had communication with several who were here during the holidays and attended the Review week and who found the work helpful.

Dr. Martha Petree of Paris, Ky., says in part "Since my return I am constantly being assisted in my work by practical things I learned from the lectures. Among the things that have been most helpful to me I recall the careful instructions on making and applying plaster casts the lecture and clinical demonstrations on hip-joint disease and Potts' disease; the lecture on serum therapy- the useful hints on treating blood poison and the various dressings for wounds, ulcers and burns; and the countless answers to questions asked on various subjects."

Dr. Ethel L. Hearst of Salina, Kansas says "As students we feel that after we have listened to a few lectures on any of these subjects we know a good deal about them, but after a few years of practice we find that we come in contact with cases that require our utmost knowledge and skill and yet we are baffled sometimes, and just as we read from various sources on our cases and find a little in one book or another that aids us, so these lectures and clinics seemed in a very large measure to be helpful. A more profitable week could not have been spent by any one in search of strictly osteopathic and surgical information. That Review Week be made an annual feature at the A. S. O. is the desire of all who were enrolled."

* * *

After this issue, THE BULLETIN goes on its annual vacation. When we come back in the fall we will all have taken one more step forward. We Freshmen will be Juniors, we Juniors will be Seniors, and we Seniors will be with you out in the field. The Axis Editor wishes to say to all of you, Freshmen, Juniors, Seniors, Field Members remembers, that all who wear our Axis pin belong to one big family and what one does is always interesting to the rest of us. So while you are enjoying your vacation think of the rest of the sisters once in a while and if you have any interesting experiences write to the Axis Editor and tell her about them so she can tell the rest of the family.

We here in Kirksville, who are trying to make The Bulletin a success wish again to thank the field members who have responded so willingly to our call for help. When we come back from our vacation we hope to take up the work with renewed strength and enthusiasm and we trust that those in the field will stand by us and that THE BULLETIN will become a necessity to every Axis member.



ASIS GRAND CHAPTER.

President, Dr. Bertha Burdette, Suite 816 Carleton Bldg., St. Louis, Mo.
 First Vice-President, Dr. May Vanderburg, 2099 Sutter St., San Francisco, Calif.
 Second Vice-President, Dr. Margaret B. Carleton, Post Office Bldg., Keene, N. H.
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Escort, Dr. Almeda J. Goodspeed, 126 State St., Chicago, Ill.

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CONSTITUTION AND BY-LAWS:—Dr. Pauline R. Mantle, 404 Pierik Bldg., Springfield, Ill.; Dr. Carrie P. Parenteau, 6540 Yale Ave., Chicago, Ill.; Dr. Ethel L. Hearst, 122 N. Santa Fe Ave., Salina, Kans.

I have not said one word about dues for some time, but I assure you through no fault of mine. Silence, however has not been fruitful—two members only responding. I wonder if you realize how close we are to the annual meeting and the falling due of another year's dues—that your present year is not paid for, yes, and with the majority of you, the past year remains unpaid. Isn't that a rather sad state of affairs for Grand Chapter members?

How many members are preparing for the San Francisco meeting? The time is short now.

Dr. Jeanette Hubbard Bolles of Denver, Colo., has been appointed chairman of the Childs' Hygiene Committee for the Congress of Mothers and is scheduled for a lecture before one of the circles of the Mother Congress. Dr. Bolles also delivered recently a lecture on osteopathy before a study club; gave a talk on Health before the Queen's Daughters and Social Union Club and lectured at Fort Collins.

Dr. Lucy Blanchard of Lincoln, Nebr., in conjunction with Dr. Chas. Blanchard, is advertising a new treatment with great display headlines in the local papers—"Ozone-O-Line Treatment." "The Great German Method of Treating the Blood Through the Lungs." It appears as if the Drs. Blanchard had turned their osteopathic Infirmary into — what?

Tell Berggen, M. D., continues to furnish "Good Health" with articles almost osteopathic.

CASE REPORTS.

The following is the report of a case which proved interesting and instructive, if not satisfactory.

The patient was unmarried, thirty-two years of age.

Family history negative except that father had "liver trouble" as a young man, but outgrew it later, and mother was "nervous" from a lack of mental poise, a condition from which the daughter was singularly free. Both parents and one brother are living, all in good health. At eighteen patient took a position in a telephone office, which required long hours over a desk. At twenty-seven there was a history of "nervous prostration" lasting for a year, and necessitating the withdrawal from work. She was given a rest cure, recovered perfectly, and from that time on had a position as clerk in congenial surroundings.

Her health again began to decline in February, 1909, but she stayed at work until August, when she went to the country for a rest. Not improving, she returned to city and consulted a stomach specialist, who pronounced the case one of stricture of the oesophagus. There was by this time marked dysphagia, accompanied by the vomiting of masses of clear mucus. Liquids were swallowed with quite as much difficulty as solids, if not with more, and it was impossible to take any food which was very warm or highly seasoned. Associated with this was extreme emaciation, abdominal tympanites and severe pain.

I was called August 31 and found conditions as described.

Later pronounced jaundice developed. The advisability of insert-

ing a tube into the stomach and feeding through it was discussed and abandoned. Patient died on October 10,—for four days previous she was comatose and unable to swallow even a drink of water.

The autopsy showed a tubercular stricture of the lower end of the esophagus, another at the pylorus and a third in the gall duct. The stomach was thickened and atrophied, other organs normal,—the gall bladder distended with bile.

The noticeable point of the case was the absence of fever throughout the illness, and of anything resembling abscess formation.

Nature was struggling to cure the case, and the patient died of starvation rather than the disease. The meteorism I attributed to the absence of bile in the intestines.

The question is as to the point of entrance of the infection, and why it should have developed where it did. The only marked bony lesion was a lateral second cervical, but there were few symptoms associated with that. There was of course rigidity of all the spinal muscles, but I judge that arose and increased as the disease progressed. Chest expansion was good and the configuration of the thorax above the average. The patient had been accustomed to singing in public and breathed well, a habit which may have saved her lungs.

The menstrual function had been normal until two months before her death when it ceased suddenly.

So far as I could gather there was nothing to suggest a tubercular infection earlier in the disease, unless it were the attack of nervous prostration, which I do not have doubt was the beginning of the malady.

ELIZA EDWARDS, D. O.

Cincinnati, Ohio,

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THE PACIFIC MONTHLY.

Toast given by Dr. Jennette H. Belles at the banquet of the State Osteopathic Meeting held January 7th, at Albany Hotel, Denver, Colo.

You can doubtless surmise the line I shall follow in talking upon the subject, "The Pacific Monthly." The Pacific suggests California, California suggests San Francisco,—San Francisco suggests the next meeting of our National Convention which will be held as near the 6th of August as practicable, and thus will commemorate the 82nd birthday of our beloved and honored founder.

So I speak of the A. O. A. and Dr. A. T. Still. Ethnologists tell us that the human race probably had its origin on the wild wastes of the plains of Asia and history teaches us that ever since "Westward

the star of Empire takes its way." This restless moving spirit was still beckoning westward when Dr. Still was born—at that time our frontier was still very close to the Allegheny mountains, now it has been pushed farther and farther until it has disappeared beneath the waters of the blue Pacific.

Traveling westward in the vanguard of our pioneers from Virginia to the then far western territory of Kansas came the man whom we most delight to honor.

In the primitive environment of wilderness, savage and wild beast, devoted his life to studying the problem of healing the sick and suffering, the mistakes of the past pointing to a newer and better way. At last, the greatest and best achievement of a great and glorious century, Osteopathy was born.

In our ever advancing civilization osteopathy is in the vanguard. Nothing can interfere with its onward march.

When in 1874 Dr. Still left the old world of medical healing and started out on the unknown seas on a voyage of discovery, he could well be likened to Columbus as described by the California poet:

"Behind him lay the gray Azores,
Behind him Gates of Hercules;
Before him not the ghost of shores,
Before him only shoreless seas.
The good mate said: "Now must we pray,
For lo! the very stars are gone;
Brave Admiral, speak, what shall I say?"
"Why say, 'Sail on, sail on, and on.'"

Hence it behooves us to be true to the standard set for us. Let us move on, and on, and do it literally during this coming summer, till we meet 1,000 strong on the shores of the grand old ocean. Whether we will it or not, osteopathy will move on and on. Shall we move on with it or shall we be left behind fossils and driftwood floating in the wake of the tide of progress?

If it be necessary for the older professions to meet in convention—in order to keep abreast of the times, how much more important for us; the representatives of a young and growing profession with as yet no literature and but few text books. Beside we have not only to keep up with the marvelous growth of our infant profession, but we have to carry on a campaign of education as well. What the general public does not know about osteopathy and the subjects upon which it is founded, anatomy and physiology, would fill not a volume merely, but a library. Any new method of convincing the public that osteopathy

is not another name for massage is quite as valuable as some idea that is purely technical.

Many so-called intelligent persons could give no better idea of anatomy than the school boy, who said—"Our anatomy consists of three parts, the head, the chest and the stomach. The head contains the brains, if any; the chest contains the lungs, and a piece of the liver,—while the stomach contains the vowels of which there are five, a, e, i, o, u, and sometimes w and y." Or the old woman who was told by the Doctor's assistant,—“Madam, the Doctor will now examine you in the ante-room.”

Turning to her husband she asked Dennis, what does he mean? “Whist, woman, 'tis the Latin for stomach.” A very intelligent woman (upon other subjects) asked for the location of the appendix, after locating it in her right iliac fossa—she asked—“and where is the other one?”

A lady recently came in for examination, upon her return home she told a friend that I found she had uterine trouble. Why, exclaimed the friend, “I never knew you had any trouble with your throat. (She doubtless confuses uterus with uvula).

Another in telling of her trouble with her back, said—she had had both of her spines affected. Such instances could be given ad infinitum.

So in the words of the immortal Greeley, “Go west, osteopaths, go west.” Let us each and every one, tonight, plan to join the caravan that is to cross the Great American Desert in the summer of 1910—and gathering on the shores of the great Pacific, let us not only help ourselves by adding to our fund of information, and broadening the scope of our understanding, but also unite to do honor to him, who in all this broad land of ours is most deserving of the love and gratitude of his fellow-men.

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THE A. O. A. READING COURSE.

I have been especially interested in the A. O. A. reading course as outlined by Dr. Woodall, and think it is a good idea to call the attention from time to time to the existence of this very important feature of our work.

We become so engrossed with our professional duties that some times we are prone to be a little careless in regard to keeping posted on things with which we may, at one time, have been very familiar, and fail entirely to keep abreast of the times by reading the new literature which could be of great benefit to us.

Some may think as they glance over the outlines of the different subjects that they are very elementary, and only a review of things

they had at school; but I believe on second thought you will agree with me that with the practical knowledge obtained since you began your professional career you are now able to look at them from a different view point, and to apply principles which were unthought of at the time you first began the work.

This was especially impressed upon my mind some years ago when I was reviewing the anatomy of the pelvis. I was studying to get some light upon a case of vaginismus which had been baffling my efforts. It suddenly became plain to me that an irritation to levators ani muscles, from rectal disease might produce contraction of vaginal sphincters.

Working upon this theory I made a thorough rectal examination and found a bad case of hemorrhoids, with extremely contracted sphincters, due in a measure at least, to displaced coccyx. I here had the cause of the trouble, and it was not long after removing cause that a cure was effected.

Another case of vaginismus caused by urethral caruncle, was cured by surgical removal of the growth.

There might be many more cases cited but we have all had some such experiences showing how valuable it is to keep posted on the anatomy of the body. Just the remembrance that the pudic vessels and nerves cross over the ischiatic spine in their course out of, and back into the pelvis, is a suggestion that they may be readily reached at this point, and also that tight muscles in this region may interfere with their function.

I am simply throwing out these hints, so that if any of us have become careless in regard to systematic reading, we will make a new resolution at the beginning of 1910 and take up at least one subject in the reading course, to which we will devote not less than thirty minutes a day during the year, using not only the suggestions of the Director of the department, but doing as much collateral reading in addition as time will permit.

ELLA D. STILL,
Director of Gynecology.

LOCATIONS AND REMOVALS



- Hilliard, Dr. Annie E. Bell, from Bradford to Haileybury, Ontario, Canada
McCaslin, Dr. Annie, from New Castle, Pa., to 908 Center St., Wilkinsburg, Pa.
Morrison, Dr. Martha A. located at 1021 11th St. Greeley, Colo.
Murphy, Dr. Verna Roberts, from Kirksville, Mo., to 2728 Ingram Block, Eau Claire, Wis.
Plummer, Dr. Ella Bissell from Madison, Wis., to 50 Cleveland St., Orange, N. J.
Thompson, Dr. Margaret, from Kirksville, Mo., to 817 Talleyr and Ave., Jacksonville, Fla.