THE BULLETIN

OF THE ATLAS AND AXIS CLUBS.

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TUBERCULOSIS.*

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(Continued from March Bulletin.)

TUBERCULOSIS OF BONES. First, I wish to say that tuberculosis chiefly attacks the bones near the articulations. For example, we never find tuberculosis in the middle of the femur. When tuberculosis attacks bone, it attacks the softest portion. The ends of the bones are more rarefied, and for that reason they are less resistent. It attacks the ends of the bones which go into a joint—hip, shoulder, elbow or wrist, and we find tuberculosis sometimes about the articulations in the skull and tuberculosis of the small bones of the ear. You never find tuberculosis in hard bone.

Common Forms. The two most common forms, are tuberculosis of the hip and of the spine. These diseases come on most frequently in childhood, on account of the fact that the bones in childhood are more rarefied than they are later on in life. On account of the fact too, that children are more frequently injured in playing, and subjected to bumps and thumps and falls more frequently than are grown-up people.

HIP-JOINT DISEASE. The reason I always take this subject up in my practice class, and discuss it a good many times in my clinics every year, is on account of the fact that some members of the osteopathic profession have made serious mistakes in regard to the diagnosis of hip-joint disease. Those mistakes have done the profession more or less injury, and especially have injured the individual practitioners who made the mistakes. The common error is to diagnose tuberculosis of the hip as a dislocation and treat it as such, with the result that the joint is often broken down. I have even seen patients so injured that they died from bad treatment,—the tubercular joint broken down, mixed infection taking place, and amyloid degeneration of the kidneys occurring.

Bad treatment in tuberculosis of the spine or hip-joint if it does not kill the patient, will cause a very bad permanent deformity. On every

*Lecture delivered to 1910 Class in Practice.

occasion that I have cases of this kind and present them to the clinic, I try to impress on students the necessity of the use of great care in the diagnosis and treatment in all forms of joint inflammation; they should not to be too ready to diagnose every lame condition of the hip as dislocation, because the worst cases of this kind are not dislocations but diseases of the joint and of the bone.

Etiology. The cause of hip-joint disease, or tuberculosis of the hip-joint, is the tubercle bacillus which infects the hip-joint following injury. It is hardly possible to have tuberculosis of the bones or joints without some injury preceding. There is usually a history of slight injury to the hip, and then in the course of several months lameness develops. Usually we can get such a history but not always. Sometimes the trouble comes on slowly without any history of injury, but we assume, as we get a history of injury in 75% to 80% that injury is present in all cases, and it is the principal factor. The child may possess a special susceptibility to the disease. In tuberculosis of the joints we often get a history of tuberculosis in the family, perhaps some other form of tuberculosis, the father or mother having died with tuberculosis. There is often inherited predisposition and then infection with the tubercle bacillus. The disease comes on so slowly that you should not have any trouble if you get a good history of the case, in differentiating it from other hip deformities and from other causes of lameness where the hip is involved, particularly dislocations.

Pathology. The primary focus is usually in the epiphysis of the head of the bone; it spreads from that point throughout the head of the bone and into the neck of the bone; into the acetabulum and into the joint cavity, in the bones forming the acetabulum, and if the disease progresses, as it usually does, it will result in complete destruction of the hip-joint. The bone erodes and the soft tissues break down, permanent shortening develops, producing a deformity which cannot entirely under any condition be corrected, as the joint is destroyed.

Onset. In tuberculosis the trouble comes on very slowly; perhaps it will be six months or a year developing before the child is so lame that he cannot get around in good shape. I have had cases where the trouble was coming on for two or three years before it developed so extensively that it interfered with locomotion.

Symptoms. The symptoms of hip-joint disease are just about as follows: There is history of injury, perhaps the little fellow has fallen and hurt his hip. He is a little lame for a few hours, or a day. He gets over that, runs and plays, and is well apparently for several months. Then he develops a little trouble in his hip and will limp for a few days. That will disappear and he will be all right. In a week or ten days more he will limp again. It comes back and disappears until in three or four months he will limp all the time and the limp is a distinct hip limp. It is due to the fact that the hip gets a little stiff, and the child carries the lame side a little ahead of the other, and does not take as long steps with the lame leg as with the unaffected one. It will be noticed that the diseased limb is a little longer than the other. Somewhat later on the leg becomes a little more rigid, and he has more pain in the hip and pain also in the knee; finally he walks with great difficulty and cries with pain, particularly at night. He does not sleep well, has bad dreams, wakes up and cries a number of times. That cry-is diagnostic of chronic bone inflammation. It is so diagnostic of hip-joint disease, or chronic bone inflammation, that it is known as the "osteotic cry" and occurs in all cases of hip joint disease, particularly in children.

What causes the child to cry out and be scared? As the hip gets more inflamed, and as the disease advances there is more and more irritation in the joint, and the muscles contract around the joint. That is reflex contraction. Then the leg draws up and flexes at the knee—that is to prevent joint pressure. When the leg is extended the muscles are tightened and there is increased pressure between the head of the bone and the acetabulum, and that causes pain. These muscles are contracted all the time the child is awake so as to keep the joint quiet. When he goes to sleep, he becomes entirely unconscious, the reflexes in the muscles are lessened and the muscles relax; pretty soon the leg will drop a little to one side, that will cause pain and he will cry out. The muscles contract again and stay that way until he goes to sleep again and then in fifteen or twenty minutes the same thing recurs.

Diagnosis and Treatment. It is important to know the diagnosis before you commence to treat. Probably the hip-joint is more frequently affected with tuberculosis than any other joint in the body. Next after that we find tuberculosis of the spine affecting the bone, and then probably tuberculosis of the knee. After that we find tuberculosis of the ankle, shoulder, elbow and wrist in just about that order in regard to frequency.

Age. A great majority of cases of hip-joint disease comes on in children between the third and tenth year. The disease may, however develop at a later period. I have had a few cases developing in adults, but those cases are quite rare. You will not

find one in five hundred. A great majority of the cases come on early in life and there is a reason for that. Children are more subject to mild, slight injury, and the bones in infancy and childhood are softer and therefore more liable to tubercular infection, as tuberculosis always affects the soft parts of the bone, as the ends,—never the hard parts.

Dislocations Differentiated.

A dislocation nearly always comes from injury. We have few dislocations following disease of the joint. Inflammations of the joint following infectious disease—typhoid fever or something of that sort, but practically all dislocations we get occur in connection with injury. So the history of the case is important. If a child comes to you for treatment, and gives a history of lameness developing slowly for six months or a year, giving a history of slight injury that did not cause him to be very lame at the time, got over it readily, you should know that there is no dislocation, for if he suffered dislocation he would have been totally disabled for some weeks; he could not have used the limb at all, and there would have been other evidences.

In the next place you will not find hip dislocations in children, because they do not happen. Not one case in ten thousand. Practically all dislocations that occur in connection with trauma occur in young adults. You take any child, and before a hip will dislocate the epiphysis will separate from the head of the bone, and it is almost impossible to cause a complete dislocation with rupture of the capsular ligament in a child or infant—next to impossible. So do not look for dislocations in children, unless the congenital form.

If a child is lame in a hip which is not tuberculous, he either has a congenital dislocation, infantile paralysis, or some form of spinal disease, brain palsy such as hemiplegia, diplegia or peripheral neuritis or something of that sort, and not, in all probability, a dislocation.

You never under any circumstances get a dislocation of the hip from direct violence. You may count on that. If one falls down and hits the hip, the neck of the femur may be fractured, but from direct violence we never get a gross dislocation of the hip. What occurs in gross traumatic dislocation? The ligaments are torn. The capsular ligament is rent so that the head of the bone passes through and lies outside of it; the muscles are lacerated and the tissues around the joint are injured. There are more or less hemorrhage, swelling and inflammation following. Always we have marked physical signs occurring immediately.

By the way, it is not a difficult matter to reduce a dislocated hip if one gets it soon after the injury occurs, before adhesions form; by the

administration of an anesthetic (or even without it) a little manipulation will take it back. If the hip is not treated for six months afterwards, or even less, it will become irreducible, as the capsular ligament adheres around the neck of the femur, leaving the head outside of it. You should not have any difficulty in diagnosing hip deformities if you use judgment. Make a careful physical examination,—you should have no trouble whatever. If you dismiss prejudice from your minds, differentiating hip-joint disease and gross dislocation is not hard. Practically all gross dislocations occur in young adults. They are caused by indirect violence. Direct injury never causes dislocation but may cause fracture. Violence in producing a dislocation is directed toward the feet, knees or back. Dislocations of the hip most commonly occur from the leg being pulled to one side. In a runaway accident a man may get his foot caught in the wheel, and his leg is given a severe twist that the hip may dislocate; or if the violence is on the upper part his back and his legs are fast, it is apt to dislocate the hip.

Another thing in dislocation of the hip, you can always detect dislocation by physical examination. There is no form of dislocation where you cannot palpate the head of the bone readily. That is especially true in the common forms, the dorsal and sciatic. In all those cases, by using a little manipulation moving the limb about and feeling carefully about the hip you can feel the head of the bone sticking out very prominently on the dorsum of the ilium, Normally the head of the bone is higher than the great trochanter, so if you have a dislocation you will always find the head of the bone higher than the trochanter and where you can palpate it. If you are unable to palpate the head of the bone you have no dorsal dislocation.

In making an examination, first find the great trochanter, and examine from that point. If the bone is out of the socket you will have no trouble in palpating the head of it.

Obturator dislocations are about as scarce as "hen's teeth"—you probably never will see one,—I never have. Out of a series of 300 X-ray pictures of patients who came here for treatment for lame hips, only two or three cases of lameness were found due to traumatic dislocations. The balance of the cases were hip-joint disease, and next after that in old people the trouble was fracture of the femur, though some were suffering from infantile paralysis; some from hemiplegia, diplegia, peripheral neuritis, etc. There were not many cases of dislocation, gross dislocations, I mean. In case of dislocations remember that a fibrous socket is formed after a while. Congenital dislocations are pretty common.

Physical Signs. Here is one disease where we have some physical signs of deformity, lameness, etc., before we have any symptoms. This is one of the principal diagnostic points of hip-joint disease. I do not know of any other form of hip-joint inflammation where we do not have the symptoms first. The physical signs and stages of hip-joint disease are as follows:

Limitation of Motion. First, there is early slight rigidity of the hip on attempt to pass it through the normal movements. Take the sound limb and flex it as far as you can, abduct, adduct, circumduct and extend it—pass it through all the normal movements and then attempt the same with the bad limb; even in the early stages before there are any symptoms, or before physical signs have developed, there is a little limitation of motion in the bad hip. It cannot be flexed as fully as the other hip,—perhaps there is a couple of inches less flexion and it cannot be abducted quite so fully. This limitation becomes more marked as the disease progresses. The leg cannot be fully extended, and if you attempt to extend the limb, pushing the knee-joint down on the table, the back will bow up. That is one of the physical signs of hip-joint disease.

Limp. There is a peculiar limp, the foot turns out and is carried in front of the other, the knee being a little flexed, and the lame leg is just a little longer than the other one,—one or two inches longer in the first stage of hip-joint disease.

Stages. For the purpose of study we divide this disease into three stages. There is, however, no hard and fast line between these stages. One gradually merges into the other.

First Stage. The first stage is that of lengthening. The leg is long, and the patient suffers some pain in the knee and hip; he also cries a good deal at night in a peculiar way—the osteotic cry; there is considerable limitation of motion; he cannot move the hip well, but as yet the disease has not broken down the bone. The surface of the head of the bone and the acetabulum are intact. But the disease is in the center of the bone and is extending into the joint cavity and is beginning to involve the tissues outside.

Second Stage. The second stage is the intermediate stage between the first and third, and is the stage when the hip commences to break down,—the bone breaks down. It becomes necrotic, soft, and rotten; then that rotten, dead bone is absorbed, and the entire head of the bone may disappear. The disease extends into the

capsular ligament and the muscular tissues, and then the leg begins to draw shorter. It was long in the beginning, now it shortens.

Third Stage. The third stage is the stage of further destruction of the joint, and shortening of the leg. The acetabulum is broken down, the capsular ligament is destroyed, more or less; the muscles are still contracted, and when the joint is destroyed the femur slips up, and now instead of the foot turning out it turns in. Usually the "Y" part of the capsular ligament remains, this has a tendency to invert the leg, and there may be four, or even five, inches of shortening as a result. I have seen cases where not only the head of the bone was wanting, but the neck of the bone also, there was nothing remaining but the straight bone, and the hip was quite loose.

Any abnormality you get in the hip-joint is permanent. There is absolutely no cure for deformity that results from hip-joint disease, because we cannot replace tissue that has been destroyed. It is absolutely impossible to do anything with an old case except to improve the motion. When the deformity takes place in a bad position, it is possible to improve it by breaking adhesions under an anesthetic or by resecting the bone.

Deformity. The principal thing in the way of treatment is to prevent deformity. Deformity can be prevented if the cases are taken in the first stage. The progress of the disease can be stopped even in the second or third stage, and in that way great benefit may come from treatment.

Treatment. The first stage is before the bone has broken down. There is inflammation in the bone but the bone is still intact. If we can get the inflammation to subside—to become quiet, the joint can be saved; it will be useful, and there will be no deformity. But, if the inflammation continues, it will break the head of the bone and the acetabulum down, and there will be permanent deformity. We want to stop the progress of the disease. The following is successful in a large per cent of cases,—probably 90% under this form of treatment.

Rest. One of the very important principles in the treatment of a tubercular hip is rest.

Relieve Weight-bearing. The first thing you want to do when you get a case of hip-joint disease, if the child is still walking, is to take it off its feet. Relieve the limb from weight-bearing, because every step irritates the hip and furthers inflammation. But even in walking the hip is not irritated so much as it would be if you were to manipulate it. Take a lesson from nature. Nature fixes the

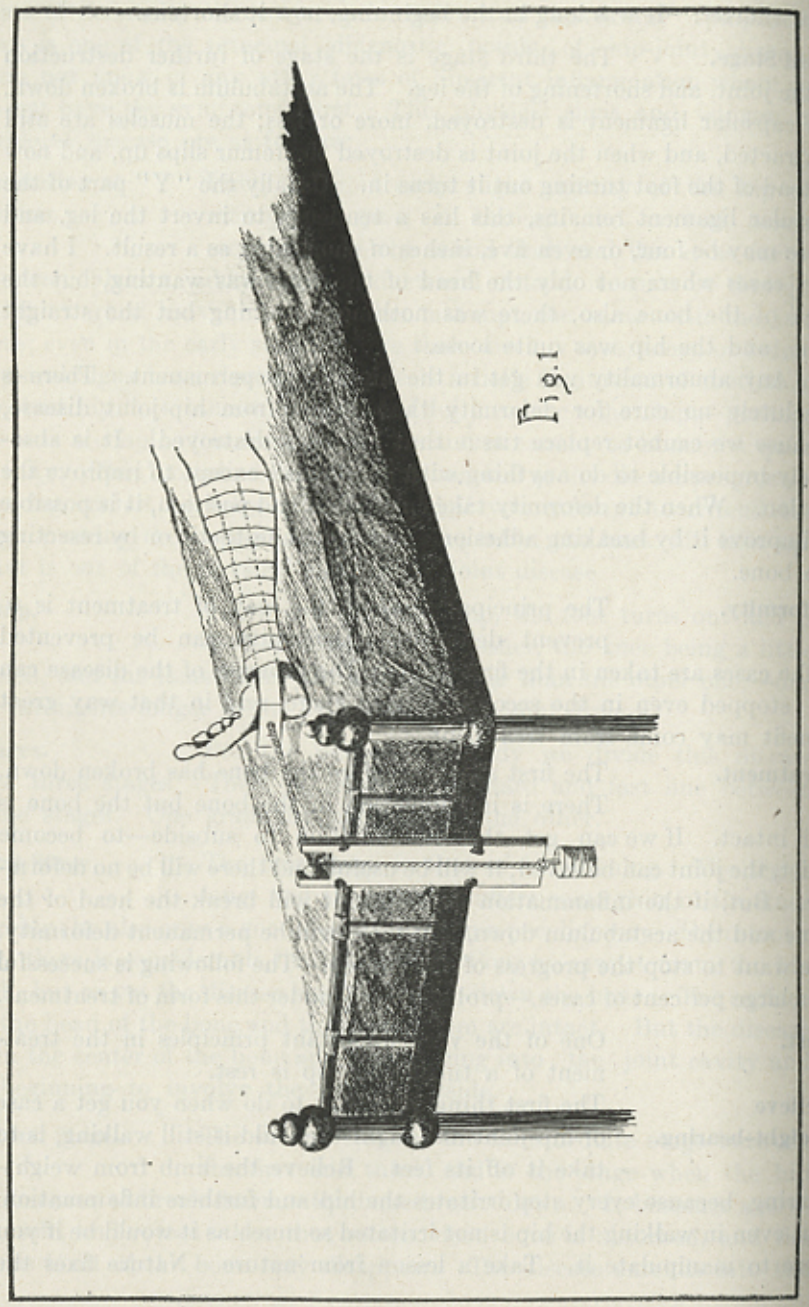

FIG. 1.—Diagram showing simple method of traction to be applied in cases of tubercular hip. Moleskin or strong adhesive is passed around each side of the foot and leg and held in place by plain bandage. A "spreader" is made of 1-4 or 3-8 inch board the width of the foot, or even a little wider. A hole is made in the center of this through which the traction cord is passed and knotted as shown in Fig. 2. A corresponding hole is cut in the adhesive, which is placed on the outside of the spreader. The spreader should be an inch or two from the sole of the foot so that the knot of the cord will not touch it. The adhesive should not be attached to the leg below the ankle. A plain board a couple of feet long (or even longer) is sawed out at one end wide enough to accommodate an ordinary spool on a shaft as shown in detail in Fig. 4. The board is fastened to the foot of the bed by clamps, the traction cord is passed over the spool and from the end of the cord is suspended the required weight to produce traction—usually one pound for each year of age of the child.

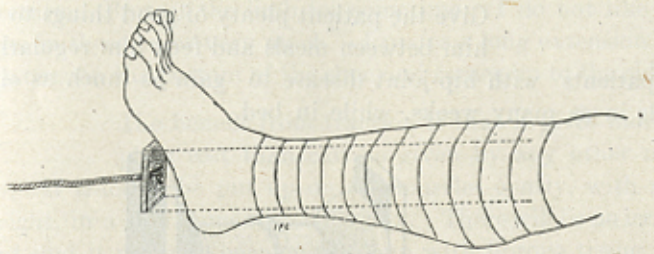

Fig.2

joint for the purpose of giving it rest. The muscles around the joint become stiff, and as long as the hip is at rest there is no pain.

Place the child in bed and put an extension on the limb. If the limb is flexed, as it frequently is in cases that are tolerably well advanced, put adhesive straps on the thigh, and let the traction come in the direction of the deformity.

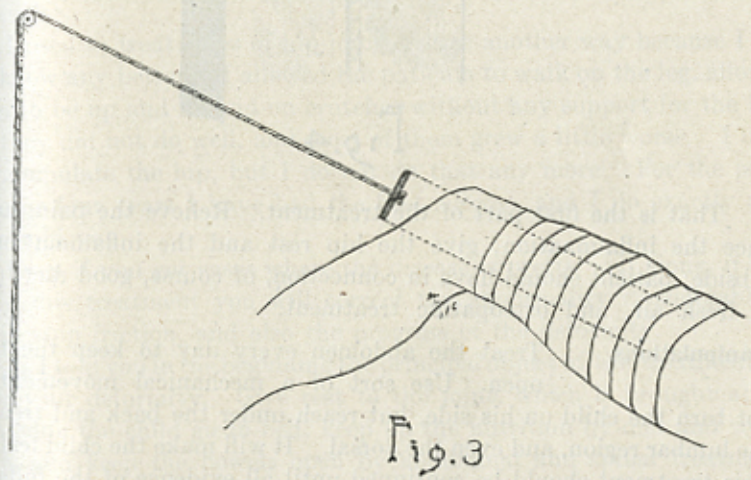

Fig.3

FIG. 3.—Diagram illustrating the method of applying the adhesive and spreader in case it is necessary to make traction on the thigh where it is found inadvisable to straighten the patient's leg in the beginning.

When the pain subsides the muscles will relax, and the inflammation abate. After a few days, or a week perhaps, the leg can be straightened; then you can attach traction to the calf of the leg, and extend it over the end of the bed (as shown in Fig. 4) and the child will be perfectly comfortable. He will have no more pain to amount to anything and will grow fat in bed, usually.

Diet. Give the patient plenty of good things to eat. Feed him between meals and feed him regularly. I have had patients with hip-joint disease to gain as much as eight or ten pounds in as many weeks, while in bed.

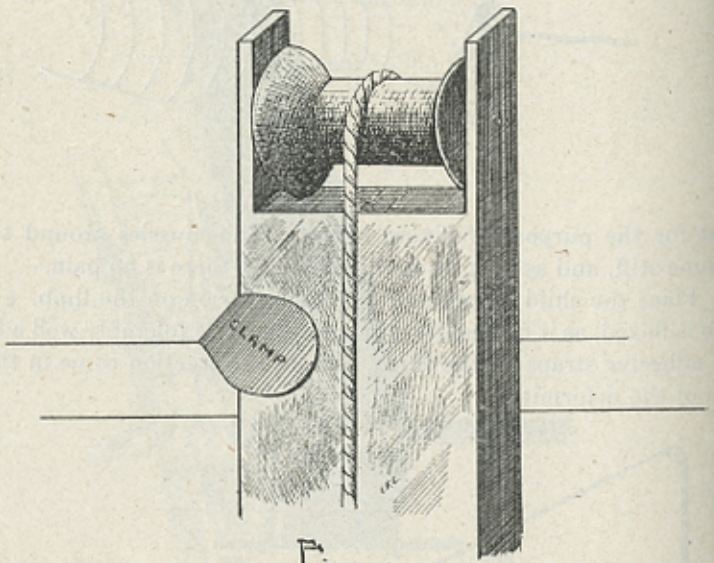

Fig. 4.

That is the first part of the treatment. Relieve the pain, and reduce the inflammation; give the hip rest and the inflammation will subside; patient should have in connection, of course, good diet, plenty of fresh air, and osteopathic treatment.

Manipulations. Treat the abdomen every day to keep the bowels open. Use sort of a mechanical movement. Do not turn the child on his side, but reach under the back and treat well the lumbar region, and even the dorsal. It will make the child feel good. This treatment should be continued until all evidence of the inflammation has disappeared, and until you can move the hip around freely,

flex it, and all that sort of thing, without causing pain to the patient.

Of course, if you get the case in the second stage, after some breaking down has occurred, even though you continue this treatment until all inflammation subsides, you cannot bend the leg, for there are adhesions. After the inflammation has abated let the child get up. Put him on crutches. Do not allow him to walk on the affected leg or the disease will return. Protect the limb for sometime. I do not like to use plaster casts in these cases very much. I prefer a long extension splint, one that fastens on the bottom of the shoe and comes up to the side.

Traction. The benefit from traction is that it gives more complete rest than can be given by any other method of fixation. If traction be put up on the muscles gently, with several pounds weight, in a short time they will relax. There will be no irritation in the joint and it will not become filled up with fibrous tissue nor be made abnormal in that way.

Crutches. The child can get around with the brace for some some months on crutches. Watch the case carefully until all evidence of inflammation has disappeared. After he has worn the brace for two or three months, gently manipulate the hip, not forcibly, but just a little. Test the motions, but do not try to break up adhesions,—manipulate it a little every day or two. If the foregoing treatment is followed, after a while the leg will be well and perfectly normal. There will be no shortening,—the limb will be all right in every particular.

I used to treat cases of hip-joint disease another way because I did not know any better. I allowed the patients to walk on the leg, allowed them to be up and around on crutches without any support for the hip, but they did not do well, and most of them grew a little worse. I used to manipulate the hip, but I do not do that any more. For the past three or four years I have had the best success, and I do exactly as I have told you.

Even if you get cases where the disease is pretty well along, if you apply this treatment you will correct the abnormality considerably—it will stop friction, and also the progress of the deformity.

As I told you in the beginning the principal object of the treatment, is to prevent deformity. Give rest to the joint, which is brought about by having the child go to bed; keep up the nutrition by diet and treatment, and keep the bowels open by abdominal and spinal treatment. If the child is putting on a little weight that will have a tendency to stop the progress of the disease, and to make his system very vital.

Complications. The complications which may arise in connection with hip-joint disease are first, abscess of the hip-joint, and that is one we do not like. There may be septicemia, toxemia, amyloid degeneration of the kidney or liver,—most commonly in the kidneys, death occuring from uremia because the kidneys degenerate and do not excrete.

Differential Diagnosis. We must differentiate hip-joint disease not only from those diseases which I have already spoken of, but from other forms of hip-joint inflammation. All of the other diseases are diseases of another character such as infantile paralysis, congenital dislocation, infantile hemiplegia and diplegia. All of those are cases where we have no inflammation of the joint. Hip-joint disease is where we do have inflammation of the bone.

There are other forms of bone inflammation not tubercular which we must differentiate in diagnosing and treating hip-joint disease,—post-infectious arthritis, for instance, which you know may follow soon after pneumonia, scarlet fever, typhoid and meningitis.

What is the difference between tubercular arthritis and some of these cases of post-infectious arthritis? Hip-joint disease is chronic. It comes on slowly and is usually sometime in developing, several months,—six or more, and follows a mild injury as a rule. All of these cases known as post-infectious arthritis follow pneumonia, typhoid, scarlet fever, meningitis, etc, and are acute. The inflammation comes on suddenly during the period of convalescence or in the latter part of the disease. It is associated with pain, swelling, intense inflammation, inability of the patient to move the limb without causing great pain, and usually there is suppuration inside of two weeks, while if suppuration occurs in hip-joint disease it does not occur for two or three years after the disease first makes its appearance. One disease is acute and the other chronic. Acute post-infectious arthritis is due to the pneumococcus or the typhoid bacillus or something of that kind,—usually the germ which produces the original disease in the hip. In hip-joint disease we have the physical signs first and symptoms follow. In acute post-infectious arthritis we have the symptoms, first and the physical signs afterward. Both diseases may end in the destruction of the joint and result in permanent deformity.

Concluded next month.

CANADA OSTEOPATHIC SITUATION.

With reference to the osteopathic battle which has been going on in Canada the past winter, the following is taken from the Toronto Daily Star of March 23rd:

"Judge Morson this morning quashed the Police Court conviction against Robert B. Henderson, an osteopathist, for practicing medicine without being registered. He was brought up at the instigation of the Ontario Medical Council.

On the 4th of February Dr. Henderson appealed before Judge Morson but his Honor would not give out his judgment until the Legislature closed, as it was understood that the osteopaths were preparing a bill on the subject of osteopathy.

Two private detectives gave evidence that they had gone to Dr. Henderson's office complaining of different pains and aches, and he had told them what was the matter and treated them by massage. Dr. Chambers testified that he did not think that Dr. Henderson made a thorough enough examination in the case of David E. Kissock, one of the detectives, who was told he had pleurisy, proceeding only, as he did, from the back and spine.

Judge Morson quashed the conviction on a judgment of Mr. Justice McMahon, which stated that practising medicine entailed the giving of drugs for curing or mitigating disease.

'There appears to be no case holding that medicine can be practised without the use of medicines,' says Judge Morson.

'There was no medicine administered in this case. If the Ontario Medical Council desire the meaning of the word medicine extended to cover the present case they must apply to the Legislature.'

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TYPHOID FEVER.

THE BULLETIN has contained during the present year more or less on this subject, but there are some good points in a paper prepared and read by Dr. L. L. Lumsden of the United States Public Health and Marine-Hospital Service at the annual meeting of the municipal health officers of Ohio held at Columbus, Ohio, January 20, 1910, which should be carefully considered.

While this paper was prepared for the information of Health Officers, there is so much of value in it for physicians that we reproduce excerpts.

"The prevention of typhoid fever stands out clearly as one of the most important problems in sanitation now confronting us in America. The measures required to prevent the spread of this communicable dis-

ease are known, but the practical difficulties encountered in getting the known measures carried out constitute the problem.

The widespread and continued high rate of prevalence of this thoroughly preventable disease in the United States should be, and is beginning to be, considered a national disgrace.

According to the United States census report for 1900, the average typhoid fever death rate in the United States was 46.5 per 100,000 inhabitants. This means that in the census year, which may be taken as an average, there were about 500 cases of, and over 46 deaths from, typhoid fever among every 100,000 persons composing the American nation. The total number of deaths from typhoid fever recorded that year was 35,379, which gave typhoid fever fourth place on the mortality list.

The rate of prevalence of typhoid fever in the United States in comparison with the rates in other countries is high. Some of the European countries now having relatively low rates formerly had high rates. Their climatic conditions seem to be as favorable to typhoid infection as those of the United States as a whole. Therefore, it appears reasonable to conclude that their decidedly lower typhoid rates are due to better enforcement of the measures which prevent the disease.

The familiarity of the public with typhoid fever, besides having giving rise to many erroneous views regarding the etiology of the disease, has caused an unfortunate tendency on the part of people generally to accept the occurrence every year of a certain amount of typhoid fever as inevitable. For much of the popular ignorance in regard to the etiology of the disease, and for the too frequent adoption by the public of a fatalistic view in regard to its occurrence, the medical profession is largely responsible. It should be considered a duty incumbent upon practicing physicians, and upon health officers particularly, to embrace every opportunity to prevent or correct there erroneous views, and to convey to the layman such knowledge as will be useful in the prevention of disease and death.

Even at the present time it is not unusual to hear it said by those who should be better informed that typhoid fever "comes only from a run-down system," or that the disease is "infectious" but not "contagious." Not many years ago the disease was regarded rather generally as being wholly, or almost wholly, a water-borne disease, and the purity of a community's water supply was estimated from its typhoid death rate. By careful epidemiologic studies of the subject it has been learned that in some communities there may be a high typhoid death rate due largely, or even entirely, to factors other than water in

the spread of the infection; and sanitarians now regard the rate of prevalence of typhoid fever in a given community as a fair measure of the sanitary intelligence exercised by that community, not only in regard to the water supply but in regard to all other factors concerned in the transmission of typhoid infection.

The occurrence of yellow fever at some place in the United States will attract widespread attention, and as a rule heroic measures will be adopted to eradicate it. It is probable that in the United States more deaths have been caused by typhoid fever every year in the last decade than have been caused by yellow fever in the last fifty years; yet in many communities in which typhoid fever is highly prevalent year after year nothing is done to lessen or eradicate it, simply because the people have become accustomed to having it and do not demand that anything be done to prevent it.

As the attention of children is attracted to new toys, so is the attention of grown-ups attracted to the new and diverted from the old, and perhaps vastly more important, problems.

From the results of recent investigations it is estimated that there are now in the United States about 5,000 cases of pellagra. From the obtainable data it may be estimated that there have been in the past twelve months in the United States about 400,000 cases of typhoid fever. The occurrence of pellagra in our country is a comparatively recent discovery, and it has attracted widespread and keen popular interest, while typhoid fever, a disease which, at a conservative estimate, causes annually in the United States fifty times as many deaths as does pellagra, attracts little popular interest except in occasional instances of outbreaks, such as those caused by a bacillus carrier or by highly infected water or milk, which present unusual features.

In order to get sufficient interest aroused in our old problems of disease prevention, it seems necessary to present these problems in new attire, so that they will compel attention. The excellent effects on the campaign against tuberculosis which were accomplished by the International Tuberculosis Congress held in Washington in the fall of 1908 suggest the advisability of having some time in the near future at some place in the United States a typhoid fever congress, either national or international in scope, to be conducted on the same general plan as to exhibits, scientific papers, etc., as was the International Congress on Tuberculosis.

All the evidence obtained by epidemiologic studies of the disease seems to support the now quite generally accepted view that typhoid fever is a communicable disease spread from person to person, and

that the disease is communicated when the germs in the excreta (feces, urine, and, in rare instances, the sputum) from infectious persons (typhoid fever patients and typhoid bacillus carriers) are conveyed in some way to the alimentary canals of other persons. There appears to be no longer any room for reasonable doubt that the disease is "contagious" or directly transmissible from the sick to the healthy, and that it is also "infectious" or indirectly transmissible from the sick to the healthy. If these views be correct, the actual infective agent must be parasitic in nature and dependent on man as its permanent host for its perpetuation. There is abundant evidence presented by the results of epidemiologic studies, however, that this agent will live for a variable time, depending on a number of different conditions, after being discharged from the human body.

Concluded next month.

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OSTEOPATHY vs. SURGERY IN APPENDICITIS.

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

(Continued from March Bulletin)

The twenty-fourth of April has been set apart for instructing the people in regard to tuberculosis, its prevalence, contagiousness, curability, etc.

The plan is a good one and I now and here suggest that the next subject for popular discussion shall be appendicitis compared with tuberculosis as to incidence, treatment, curability, etc.

The following clipping from the "Youth's Companion" indicates the "radical operation" for those affected with that dreadful disease appendophobia. If that great nerve center, the brain, is not entirely paralyzed by the disease, the latter can be "killed by a nasty ugly little fact." Huxley, the brilliant English scientist and man of letters was unusually quick and subtle at repartee. Once while dining with Herbert Spencer and another friend at the Athenaeum, the conversation flagging Spencer remarked:

"You would little think it, but I once wrote a tragedy" Huxley answered promptly, "I know the catastrophe."

Spencer declared it was impossible, for he had never spoken about it before then. Huxley insisted and Spencer asked what it was. Huxley replied:

"A beautiful theory, killed by a nasty ugly little fact."

Since my last article not however a case of propter hoc but mere post hoc, a warm discussion has arisen among members of the medical profession as to the "Question of Priority in Medical Treatment of Appendicitis." This is one of the good indications. It proves that neither the ipse dixit of Surgeon General Nix, nor the great influence of Lieutenant General Avarice is able to control all the members of a great profession.

There is some excuse for the very general acceptance, by medical practicians, of the theory that all cases of appendicitis are surgical. There seems to have been "an agreement among gentlemen" for the purpose of getting all of these cases to the surgeon. The first move was to divide the spoils with the man who furnished the material. The next was to "subsidize the press" or by more objectionable methods to control the teaching of the medical journals on this subject.

As an indication of the fearful effort to prevent any of these cases getting away from the appendectomists, witness the following from the "Year Book" for November, 1902 General Surgery, Murphy Editor. In this volume there are twenty references to appendicitis while in the volume on General Medicine October, 1902 the subject has not a single reference. (I refer to the index of each volume). This indicates how completely the appendectomists have the market under control. It appears that with the exception of the cases under the care of the osteopathists and homeopathists they had almost a corner on the supply. When the patients died following the operation, the death was attributed to anything but the operation, as the following extract from the volume on Surgery, above mentioned, indicates,—"The Mortality of Appendicitis. During 1900, 268 cases of appendicitis were operated upon at the German Hospital by J. B. Deaver. Of this number 144 were acute attacks and 124 chronic. Of those during the acute stage, 26 died, either from the disease or from some intercurrent trouble arising during the illness, or existing prior to operation. If we deduct three cases, the mortality of this series is 15.9 per cent for acute appendicitis without intercurrent disease."

Ochsner, at the A. M. A. later proved that this fearful mortality was due to the operation and not to "the disease" or to "some intercurrent trouble." I have not the space to go into the details of this most interesting chapter concerning the work of those who were, at that early day, standing between the 'quick and the dead.' From the same article from which a paragraph is quoted above I make a few more short extracts to show the status of medical literature on the subject in the early part of this decade.

"Our main interest is the causes of fatal termination in cases sub-

mitted to surgical treatment. In chronic appendicitis without adhesions, or acute cases operated on during the attack in which the lesions do not spread beyond the pertioneal coat, the mortality is confined entirely to causes inseparable from any celiotomy. Septic peritonitis due to errors of technic, hemorrhage from ligatures slipping, nephritis and pneumonia during convalescence, and the unavoidable dangers of anesthesia."

"There is one class of cases, however, in which, in the great majority, a lethal termination is reached in spite of any treatment. These can be appropriately called fulminating. In them, operation is too often unavailing, as the first symptoms are those of general peritonitis.

"Another very common cause of death in these cases is necrosis of the bowel, probably due to septic emboli in the veins of the mesentry, or pressure from plastic exudates. Metastatic abscesses, septic endocarditis and obstruction of the bowel also account for the death of some. Ether for some unexplained reason is especially badly borne by these patients, and adds greatly to the anxiety of the operator."

"Girl of seven, with a cough for two days, abdominal pain and tenderness, no operation advised, pneumonia developed; recovery. The symptoms might well suggest acute appendicitis, even in the presence of a pneumonia or a threatening pneumonia."

The versatility of the appendectomist is the one character that commands my profound respect. Having been driven from the position "always operate as soon as you reach the patient" to "always operate as soon as you reach the patient provided it is not more than forty-eight hours since the beginning of the attack" to "always operate as soon as all indications of inflammation have subsided" to "always operate, following Deaver's technic" to "always operate following Ochsner technic," etc., adinfinitum, adnauseam. He says:

"Finally brethren, if the patient and the family, and the attending physician all oppose an appendectomy and contend for medical treatment, advise for an appendicostomy. You can show by the 'highest authority' that if medicine is to be used for this or any other disease it is best introduced into the system by an opening in the appendix and not per orem or per rectum, this is also true of foods." By this plan the appendix artist saves his face (cheek)? so to speak, likewise his fee and also retains the reputation of being up to date."

Of course, those who still cling to the practice (habit)? of using opium to 'splint the bowels' will find the os appendix a far preferable means of getting the opium just where it is wanted, than any of the old style methods, such as the mouth, rectum or hypordermic. This advice

in spite of the fact that the action of opium is systemic, and also the more serious fact that the bowels need emptying not "splinting." Well, here again our versatile friend the appendicostomist shows his genius by claiming that the only proper, scientific and up-to-date method of evacuating the bowels is by the use of his os appendix whether the agent is an enema or a carthartic. A large syringe is to be used and with the patient in a sitz bath the technic adopted can be either the push or pull method.

This suggests the following lines:

" 'Tis very strange that you and I together can not pull
For I am full when you are dry and dry when you are full."

The os appendix being thus used as a port of ingress or egress as the artist may decide.

We give another quotation which shows that an off hand diagnosis of appendicitis is not so easy as some would have us believe,—

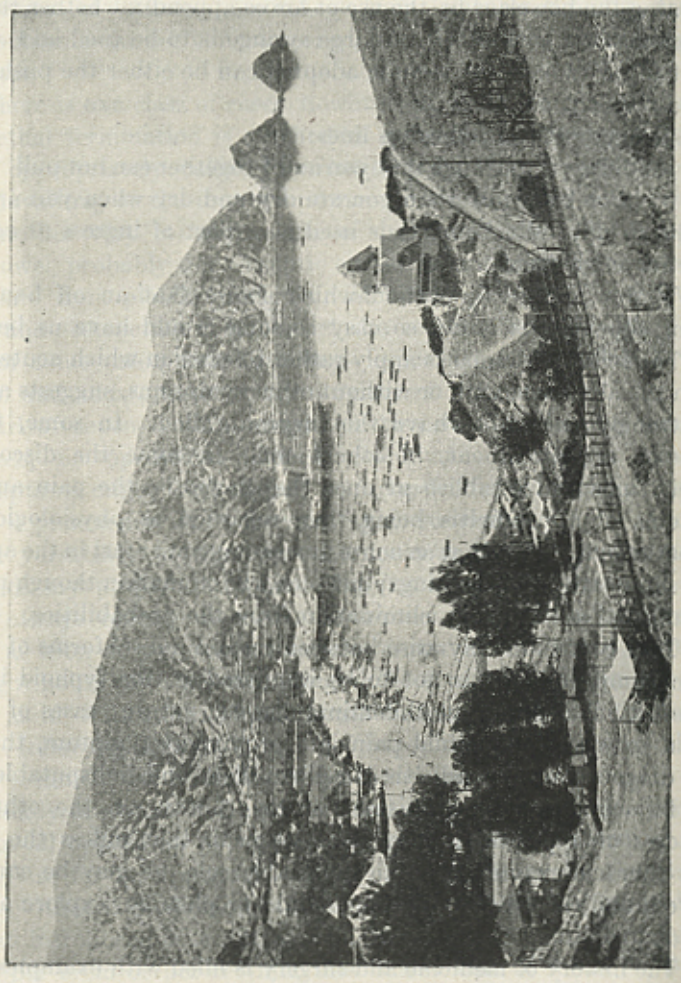
"The following remarks apply rather to cases in which acute sudden pain in the abdomen, with or without other symptoms, suggests appendicitis strongly enough to have the surgeon called. In some, thoracic symptoms are prominent, in others not. In some the discovery of thoracic signs will establish at once the diagnosis, the pain and other symptoms of appendicitis being then regarded as physiologic rather than pathologic. Not that an acute process may not start in the appendix at the same time as in the lungs; but such a combination though possible, is so unusual as to justify elimination from the probabilities.

"That confusion may arise between certain unusal forms of typhoid and acute appendicitis is not to be wondered at, for typhoid is, in its manifestations at least, an abdominal disease; yet, in cases of typical typhoid in which abdominal pain is a prominent symptom, the differential diagnosis of appendicitis is seldom clear and indisputable,

"In acute right-sided disease of the thorax, on the other hand, symptoms of appendicitis may be so typical, that unless the surgeon makes thoracic examinations an invariable rule, he may be completely deceived, and, in a beginning pneumonia or pleurisy, explore a normal appendix.

"The history of medicine and surgery is filled with examples of such errors."

Century Bldg.,
Des Moines, Ia.



THE BULLETIN

OF THE ATLAS AND AXIS CLUBS.

IRVIN FISH CRAIG, Editor. M. A. BOYES, Business Manager.

Price $1.00 Per Year.

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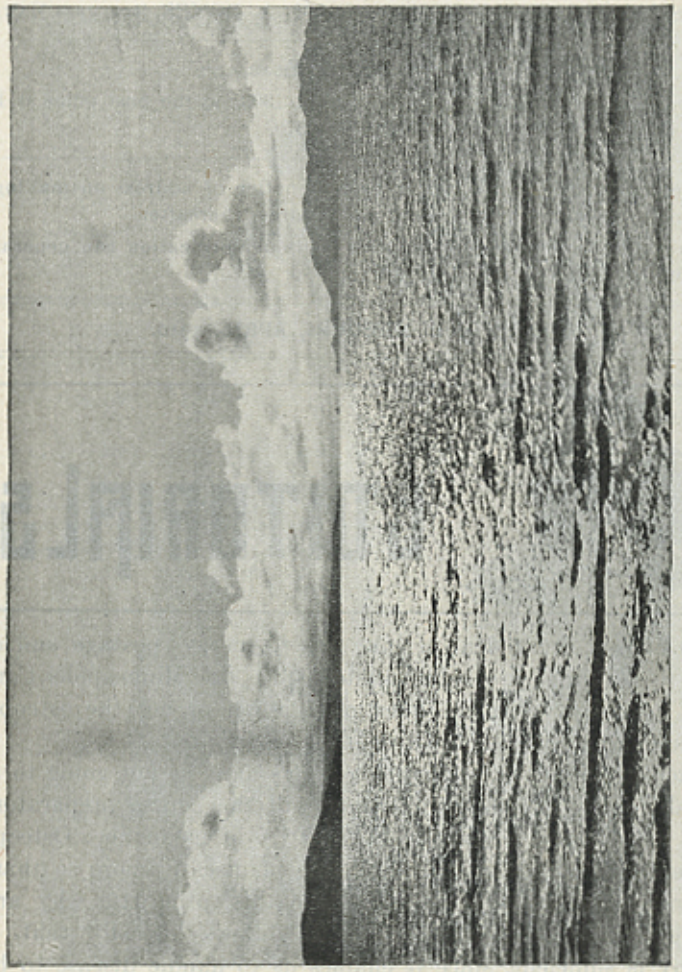
Copies lost through change of address without notification can generally be furnished by the editor at ten cents per copy.

KIRKSVILLE, MISSOURI, APRIL, 1910.

EDITORIALS.

The M. D. Degree. A great deal of ink, paper, energy, postage and other things are being wasted since the Minneapolis Convention, over the question whether or not the osteopathic colleges should grant an M. D. degree.

Attaching the M. D. degree to a man's name is not going to make a medical doctor of him, and neither will the course preparatory to granting the degree fit him for the practice of medicine. Osteopathy itself is entirely adequate to the healing of disease, more so than the administration of medicine. We believe this, otherwise why are we practicing or studying osteopathy? It follows logically that, since osteopathy is sufficient, since it enables us to handle disease to better advantage than does the medical practitioner, we do not need the M. D. degree. It would be analagous to wrapping a well finger up in a bandage. If there is any place that osteopathy is not made the equal of medicine, it is not the fault of our science, but of the practitioner himself. Hence, the obvious remedy is not to furnish a practically bogus M. D. degree, but to see that our practitioners are what they should be. We



The Golden Gate—Golden-skied and rich with opportunity for all passengers between its portals.

believe the cry to be raised in the wrong direction, and that it should be towards perfecting our practice, as individuals, rather than borrowing plumes from our neighbors.

* * *

Dollars vs. Osteopathy. It is to be deplored that so many of our profession are pursuing osteopathy solely with the thought of monetary reward. Of course it is necessary to have the income. We have to live and so do our families, and our osteopathic education represents an investment of time, money and labor, therefore it is no more than just that we should be well compensated. But to make the pursuit of the dollar the only aim of our lives, to the detriment of our science, is not right. We should give to the profession as much as we take from it. Our studies cannot stop upon graduation. Our osteopathic course merely prepares us to study, and the real knowledge comes to us only as we cope with disease and note carefully the effect of our treatment upon it.

We are told that most osteopaths are too busy making money to study their cases carefully, compile case reports, and make deductions from results obtained. Every osteopath should feel this to be his duty, but as long as human nature retains the characteristics which have made the word "American" synonomous with "dollar" there will be no change.

* * *

A. O. A. Convention. The Association has decided to hold the annual meeting sometime during August at San Francisco. There of course will be an Atlas and Axis reunion sometime during the convention as in the past, and we hope it will be the largest and best ever.

Arrangements have been made with the St. Francis Hotel for headquarters. This is one of the finest hotels in the West, and has in connection convention hall, clinic and committee rooms.

California is an ideal place for a convention, as evidenced by the large number held in various sections of the state each year, and its attractive resorts are too well known to need comment.

Arrange to be there.

* * *

Interclass Games. The interclass ball games are over. The lower classes succumbed to the September Freshmen, who were thus entitled to play for the Athletic Championship of the school which 1910 class has claimed for three years. The deciding game was played April 1, with a resulting score of 7 to 14 in favor of 1910.

The Forbidden Garden, Santa Barbara Mission, California—into this monkly paradise no daughter of Eve is permitted entrance.

April Fool. April 1, 1910, was one of the liveliest days old Kirksville has seen in a long time. Classes assembled as usual at the A. S. O. but before the lectures were well under way the Oskie-wow-wow war cry resounded from one assembly room to another and almost simultaneously the classes filed out into the street, leaving the lecturers without an audience.

The street in front of the A. S. O. was quickly filled with students, drums were procured, and the "parade" started. Drums and vocal cords vied to see which could make the greater noise. The latter easily won on account of the numbers.

The line marched to the State Normal School where Normalites augmented it in numbers and noise. The High School turned out en masse and joined. The Business College was drained of students, and the Pied Piper scene was enacted at the various ward schools. After much marching, a ring was formed around the court house square, hands were joined and the merry foolers sang, shouted and danced to their hearts' content.

* * *

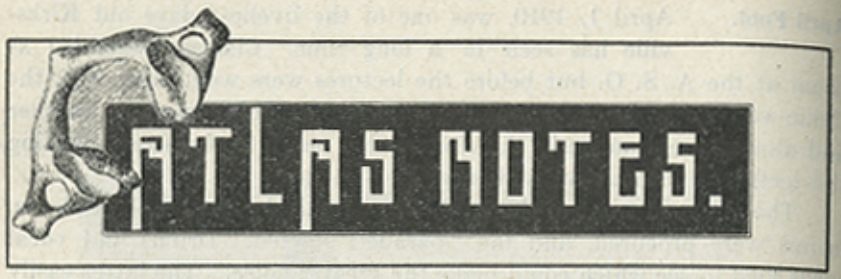
Coat of Arms. On page 148 of the November number of THE BULLETIN appeared a cut of the coat of arms adopted by the Club. Quite a few of these have been obtained by members who haveexpressed their admiration for the fitness and beauty of the design.

If you could but see the original shield, you would surely want one for yourself. It is of sufficient beauty to be an ornament in any office, no matter how well furnished. Write the Pylorus for one.

* * *

Life Membership Certificates. Atlas men are steadily availing themselves of the life membership plan. It is a good scheme for the busy practitioner, who may settle his dues for life in one payment, and be rid of the bother of making the small annual remittance, necessary to keep him in good standing, and on THE BULLETIN mailing list. It also lessens the labor of the Pylorus, who on account of the present large membership of the Club, finds his duties onerous, taken in connection with regular school work.

Since our last issue the following members have been granted certificates: Droctos A. H. Daniels, Northampton, Mass.; Fred W. Gage, Chicago, Ill.; W. E. Scott, Greenville, N. C.; T. W. Sheldon, San Francisco, Calif.; Thos. H. Spence, New York City; Granville B. Waller, Louisville, Ky.; Chas. F. Banker, Kingston, N. Y.



The evening of March 12th was open meeting at Atlas Hall, the Program committee producing the following entertainment:

March.....Atlas Club Orchestra
Vocal Solo.....A. S. Hollis
Address, "Success".....Rev. B. F. Jones
Piano Duet.....Bros. McGonigle and Illing
Selection.....Orchestra

The numbers were all pleasing. The Club Orchestra showed great improvement since last heard, and is an organization to be proud of. It is hoped that it will be supplemented as members drop out through graduation, and that the Atlas Club Orchestra will be permanent.

The speaker of the evening was very pleasing, and enlivened his address by many anecdotes, which were much enjoyed by the Club members.

The laws of achievement were spoken of under the heads of Character, Purpose, Adaptation and Imagination.

* * *

Dr. F. Austin Kerr, ('09) of Provo, Utah, in a personal letter, says that business is good with him, even though he is osteopath No. 8 to locate at Provo and No. 1 to stick there.

At the last meeting of the Utah State Osteopathic Association, Dr. Kerr was elected vice-president for the coming year. The local M. D's. treat him well, and have extended an invitation to him to join the local M. D. Association.

* * *

Dr. Norman D. Wilson, ('09) of Manchester, Iowa, brought a six year child with congenital dislocation of the hip to the hospital this month for operation by Dr. Laughlin. After working thirty minutes Dr. Laughlin found that the hip could not be reduced, no doubt due to contraction of the capsular ligament.

Dr. Wilson looks as happy as in the old days and expressed himself as pleased with visiting the school and Atlas boys once more.

Eldon S. Detwiler, who went nearly to graduation with the '09 class, and who was an active Club member while in school, but who left school to accept position as osteopathic assistant writes the Club that he expects to return in January of next year and graduate with the 1911 class. He is now practicing osteopathy in the Opera House Block, Guelph, Ont.

He says: "I have missed The Bulletin very much, and am eagerly looking forward to the coming January when I expect to be back to finish my course and get back into the Club rooms and meetings. A fellow never realizes the strength of the bonds he makes there in muddy Kirksville until he has severed them. No matter how anxious he may be to get away from there and out into the field, he has great longings to get back, if only for a short time, as soon as he has been away for a short period."

* * *

Dr. E. J. Breitzman, ('03) of Fond du Lac, Wis., in a recent letter to the Club says, "The Bulletin has grown splendidly, keeping up with the general advance of all things osteopathic and we are all proud of it."

It is certainly gratifying to the management of The Bulletin, as well as to the local chapter of the Club to have the approval of men like Dr. Breitzman.

* * *

The Club was pleased to hear from brother Walter S. Grow last month. He is practicing in Indianapolis, Ind., and writes: "I am getting along fine, and will be more than pleased to receive The Bulletin during my stay here in Indiana. Every member of the Atlas Club should make an effort to keep in touch with the publication because it is worthy of our support. Give all the Atlas boys my best regards; success to those who expect to look the State Board in the face about the last of May."

* * *

Dr. Eugene F. Pellette, ('09) of Liberal, Kans., writes encouragingly to the Club and says this winter he has had almost more practice than he could attend to. He expresses his regrets that The Bulletin was reduced in size, and thinks the field members should support it so liberally that it could always be published in the larger form. In conclusion he says: "I like especially well the lectures on practice by Dr. Geo. Laughlin and I sincerely hope you will keep them up."

* * *

Dr. A. S. Loving, ('04) of Denver, Colo., has opened a branch office at Ft. Lupton, Colo., and will spend one day per week there.

Dr. L. C. Kingsbury, ('01) of Hartford, Conn., gave an address not long since before the Hartford Dental Society, his subject being "What Osteopathy Is and Does." Its safe to say that the dental doctors of Hartford have some good information on osteopathy since hearing Dr. Kingsbury's address.

* * *

Dr. Frank H. Smith, ('00) of Kokomo, Ind., always on the alert for investments, has purchased half interest in a printing establishment in that city.

* * *

Dr. W. A. Cole, ('02) formerly of Dubuque, Iowa, believes in the scriptures—at least the admonishment that it is not good for man to live alone, hence he and Mrs. Agnes F. Deckart were ankylosed in wedlock February 14th, at Kansas City, Mo.

* * *

The Wisconsin State Osteopathic Association is a judge of good osteopaths, hence it selected two Atlas men for president and secretary respectively, Dr. E. J. Breitzman, ('03) of Fond du Lac, and Dr. E. C. Murphy, ('09) of Eau Claire.

* * *

Dr. Frank L. Goehring, ('07), was compelled to change location in Pittsburg, Pa., last month owing to a fire destroying the building in which his office was located. He suffered only slight damage by water.

* * *

Dr. Thos. P. Huffman, ('03) of Lafayette, Ind., has prospered to such an extent that he has removed to larger and better offices.

* * *

Dr. W. E. Dwiggins, who last year removed from Bakersfield, Calif., to Auburn, Calif., has returned to his former location at Bakersfield.

* * *

Dr. E. C. Murphy, ('09) of Eau Claire, Wis., is enjoying a good and steadily increasing practice. In a letter to a member of the local chapter, referring to THE BULLETIN, he says:

"Received the March Bulletin yesterday. You boys there cannot appreciate its contents fully until you get way off in the field alone, as I am, with no D. O. within fifty miles of me. Tell Craig, for me, that though THE BULLETIN is in the hands of those 1910 'ers I consider it superior to any time in its history. Dr. Laughlin's lectures sound very familiar, but are far more interesting to me now than when I heard them, for when one gets out in the field and up against the real thing in practice without the faculty back of him, then he reads, and many times finds mighty little consolation in reading medical works. Then he wants something along osteopathic lines, and while we have some good works, we have not enough.

I miss the Club association very much, and would certainly enjoy dropping in on the boys some evening.

Give my best regards to all the boys, tell them to get busy and absorb everything they can for it will come in handy later on."

* * *

Dr. Ambrose B. Floyd, ('06) of Buffalo, N. Y., is doing something in the lecture line as well as in the osteopathic.

On the evening of March 17th he delivered an illustrated lecture on Jamaica, to the guests of the Jackson Health Resort at Danville, N. Y.

The Doctor recently made a trip to this beautiful island and many of the stereoptican views were made from his own negatives.

* * *

A Reminder—Under the constitution, all field members in arrears for dues for 1910 will be on May 1st, automatically under suspension, and, thereby cut off from Bulletin list and other advantages. You have all been notified by the Pylorus in February, so why not continue your Bulletin subscription?

* * *

NEW OSTEOPATHS.

March Bulletin went to press before we learned of the arrival of another prospective Atlas man at the home of Dr. J. E. Derck in Kirksville, Feb. 26th.

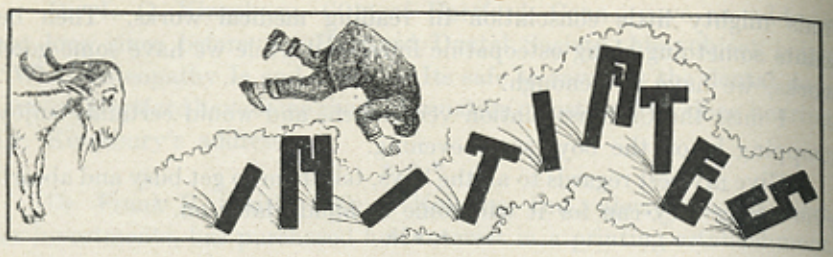
* * *

Bro. L. J. Bingham is the proud father of a nine pound boy, born March 21, 1910.

Bro. Bingham is a member of the June, 1910 class and the new boy will soon be able to assist in the office.

* * *

Dr. E. H. Parker is of a quiet retiring disposition, hence we were not advised in time for March number of THE BULLETIN that a new member was added to his family March 2nd, a prospective Axis Club member.



The following members have been received into the Club since our last issue:

H. H. Bell, formerly of Wilburn, Va., was a student Association with an osteopath first turned his thoughts toward osteopathy as a profession for himself; he then investigated its merits, and becoming satisfied, entered the A. S. O. in the fall of 1910.

Mr. Bell holds an A. B. degree from Virginia Christian College, of Lynchburg, Va.

* * *

Calvin R. Weaver was a bookkeeper at Goshen, Ind. Having seen an osteopath cure, in what seemed an almost miraculous manner, a friend whom an M. D. said would never walk again, and who had a dislocated innominate and several vertebral lesions, he concluded that osteopathy is a good profession, and decided to embrace it.

He has a high school and commercial education, and spent one year at Chicago University.

* * *

Carl A. Wohlfeld was a clerk at Grand Rapids, Mich., and through the influence of his mother decided to take up the study of osteopathy. He accordingly entered school last fall and is a member of the June, 1912 class.

* * *

John F. Harrison was formerly located in Valentine, Texas, and was by occupation a school teacher.

Mr. Harrison is one of those who took osteopathy "On faith" as he had never seen an osteopathic treatment nor an osteopath before coming to Kirksville. When asked how it was that he came to take up the study under such peculiar circumstances, he said that through the influence of a personal friend whose sister, Dr. Bessie Walling, is practicing in Norwalk, Ohio, he was led to believe that it would be an occupation which would suit him for a life work, and he accordingly came to Kirksville and took up the study.

He has no relatives in the profession, although some are medical doctors.

Chas. Dejardin was formerly a builder and contractor in Toronto, Canada, but through Dr. Campbell Black of Toronto and Dr. Henderson of the same city, coupled with the fact that his wife and her mother were benefited by osteopathic treatment, he became interested in, osteopathy and finally concluded to take up the study himself. Accordingly he and his wife entered the A. S. O. and will graduate with the 1911 class.

Mr. Dejardin is a graduate of George Heriot's and George Watson's Colleges of Edinburg, Scotland.

* * *

Dr. William A. McConnell, of Marion, Ind., is one of the new members of the Club. He was formerly at Washington, Vt., in the real estate business, but receiving through Dr. C. P. McConnell cure of defective vision, became interested in osteopathy and entered A. S. O., graduating with the class of 1899. Since that time Dr. McConnell has been engaged in the practice of osteopathy at Marion, Ind.

* * *

Clyde B. Spangler was formerly engaged as clothing salesman in Paris, Ill. Becoming interested in osteopathy he matriculated in the A. S. O., September, 1908 class.

OFFICERS OF THE AXIS CLUB.

President, Mrs. Grace Cutter Learner.
First Vice-President, Miss Margaret L. Loring.
Second Vice-President, Miss Grace D. Wilson.
Recording Secretary, Mrs. M. E. Mitterling.
Financial Secretary, Miss Pauline Sears.
Corresponding Secretary, Mrs. M. L. Payne.
Treasurer, Mrs. Lucy M. Hull.
Chaplain, Mrs. Christine M. Irwin.
Escort, Mrs. E. H. Lane.
Janus, Miss Mary S. Howells.
Librarian, Miss Mabel Fouch.
Editor, Miss Ethel D. Roop.

COMMITTEES:

CONSTITUTION AND BY-LAWS.—Miss M. L. Warner, Mrs. L. H. Holmes, Mrs. C. M. Irwin, Miss M. G. Crossman, Mrs. Fannie Stoner, Dr. Clara E. Morrow, Miss F. Nickenig.

FINANCE.—Mrs. L. M. Hull, Miss Lulu Hubbard, Mrs. E. H. Lane, Mrs. Jennie Beckler.

AUDITING.—Miss Council Faddis, Miss M. G. Crossman, Miss H. A Hitchcock.

PROGRAM.—Miss Harriet Sears, Mrs. L. H. Holmes, Dr. A. S. Gooden, Mrs. V. R. Murphy, Miss May Emery.

COURTESY.—Miss I. S. Campbell, Dr. M. Thompson, Mrs. C. M. Irwin, Miss A. Bailey, Miss B. B. Cameton.

BULLETIN.—Miss E. Brewster, Miss C. W. Weaver, Mrs. M. L. Payne.

NOMINATING.—Miss L. Carter, Miss M. Fouch, Miss L. F. Taylor, Miss M. E. Ward, Mrs. Anna Murphy, Mrs. T. V. Haven.

REVIEW WEEK.

It is with great pleasure that I respond to the request to write my impressions of the Clinic offered by the A. S. O. during Christmas week. For many reasons it is impractical for a general practitioner to absent himself from his office to take a long post-graduate course. To such a one a review week is a boon. State and national conventions serve the excellent purpose of lifting out of the inevitable rut and offering opportunity to mingle with one's colleagues for interchange of ideas with resultant benefit. Following uninterruptedly one's own line of reasoning invariably terminates in a narrowing of one's mental calibre. It is only a genius like our Old Doctor, who can create original ideas; we lesser lights can merely hope with labored perseverance to assimilate, what the scientific minds of the world work out for us. Our skill manifests itself in amalgamating the truths we find in various sources, incorporating these with our own ideas and finally making a practical application. The busy practitioner has little time for personal research and investigation, therefore we must have qualified individuals who will do this for us. These specialists separate the wheat from the chaff, thus saving us precious time, assuming that we have the ability to do it for ourselves, had we the necessary time. No professional person can isolate himself without incurring the danger of suffering arrested development. We have all known students at school and college who gave great promise of success, which they failed to realize after getting out into life. The explanation for this is the fact that their education ceased with graduation instead of beginning as the word Commencement suggests. In an unexplored science like osteopathy, new truths are being continually discovered, in the light of which cherished theories must be abandoned without however, in the least affecting the fundamental principles of our revered founder. The strongest men in our profession set us the example of being broad and openminded by modifying their views from time to time and under circumstances changing their position radically concerning ideas they had held previously. "'Tis a wise man who changes his mind."

Now, how are we to become cognizant of the best and newest in our rapidly developing science unless we keep in touch with scientific minds and the specialists in our schools who are best fitted to impart the results of recent clinical research and evidence. The A. S. O. has led the way in making it possible for the busy physician to acquaint himself with the latest information bearing on his work. The permanance of our profession depends upon our ability to progress, upon our courage to abandon any theories which time and experience prove false.

One always feels confidence in a man who, when he finds he has made mistakes in the past, frankly acknowledges them, and changes his course thereafter. I congratulate the profession on the possession of men of this calibre, men who are giving their time, strength and thought to developing our science. To them we owe our salvation. They are discovering new truths for us each year, elucidating Dr. Still's wonderful principles, opening new fields of activity and enlarging the scope of osteopathy generally. We cannot be grateful enough to those lieutenants of the Old Doctor who guide us in the way we should go, instead of allowing us to saunter along in a self satisfied condition, content with what we acquired while at school.

To the people who have been out of school a few years a return to the beloved Alma Mater is a revelation. The evidence of progress

is everywhere apparent. There is manifest in every department an ambition to raise the standard, to meet the most critical demands. The enthusiasm of the teachers is an inspiration to the eager men and women who gather there to absorb the wonderful principles of osteopathy. It was a rare treat to go back and be a student once more, as we were during clinic week.

Field experience naturally gives one keener powers of perception and absorption than one had in student days and we felt that in the cleverly condensed form in which the work was offered, we gained in a week as much as in a month's time during the school period. It is lamentable that there were not five hundred instead of one hundred in attendance. The arguments used to account for absentees was lack of time and money. Neither excuse is a good one. The fact is, we cannot afford to allow ourselves to deteriorate professionally. Invariably you will take away from these conventions enough new ideas to help you cure cases on which you previously had failed. One new idea repays for the time and expense of a trip.

What appealed to me especially about the clinic week and made it more valuable than any convention I ever attended, was the absence of all "red tape," such as the business and elections usually attending such meetings, and the useless discussions by persons not qualified to speak. One felt that every hour was spent to the best advantage.

We must not underestimate the value of state and national meetings, as our very existence as a profession depends upon strong organization. Unfortunately all within our ranks do not yet appreciate the importance or necessity of co-operation. It is difficult to understand such a pathy on the parts of thinking people toward the keystone organization upon which rests our professional existence. How can we accept all that this splendid profession has done for many of us, physically as well as financially, and not be eager to do our part toward its maintainance? Surely everyone, no matter how small his practice, can contribute a few dollars annually to state and national associations. If your reason for withholding your support is due to the fact that you do not approve of the manner in which business is conducted, lend a hand in creating better methods, but under all circumstances identify yourself with the societies which need you as you need them.

Clinic week does not seek to take the place of conventions; it is a purely educational feature and the participants found it the most helpful intellectual treat ever offered thus far to our profession. We trust that the experiment proved sufficiently satisfactory to the A. S. O. to warrant its continuance as an established custom.

BERTHA A. BUDDECKE,
816 Carleton Bldg., St. Louis, Mo.

The Editor has communicated with the Axis members who were in Kirksville during the Christmas holidays and attended Review Week and hopes to be able to publish several articles concerning the work. As yet we have not heard from all but are glad to print this month something from Dr. Bertha A. Buddecke of St. Louis.

We also received a letter from Dr. Myrtle Pleasant Morrison of Emporia, Kansas, who said, though she didn't have time to write a long article that she was glad to be put on the list of those who found the work of great profit and pleasure. She writes:

"I hope Review Week will become an established affair and I shall always make an effort to be there."

We also wish to thank the Field Members who have so willingly responded with the subscription price for THE BULLETIN. We have not heard from each one but we are convinced that, as a whole, the Axis members in the field want THE BULLETIN and have confidence enough in the sister members of the Local Chapter to believe that they have done the best they could about the matter, for all concerned.

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AXIS NOTES.

Dr. Sarah E. Carrothers of Lawrence, Kans., sends good wishes to the club and says "I hope this year will be a successful one to every one of the club members both at Kirksville and in the Field."

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Dr. E. M. Ingraham writes that her record in the Directory is incorrect; that she is a member of the class of 1901 instad of 1907 and that her address is 506 N. Vandeventer Ave., St. Louis.

We hope if there are other mistakes in the Directory, especially mistakes of address, you will let us know so we may publish the correction.

* * *

Dr. Agnes G. Lake, Boston, Mass., says in a letter enclosing the subscription for THE BULLETIN: "I enjoy it very much but often wish there were more news and letters from field members." We wish so, too, Doctor, but, as you say, we have to depend on you, out in the field, to write to us and tell us the news. Let us hear from you as often as possible for we are always thankful for anything of interest to other Club members.

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Dr. Mary Lyles-Sims writes that she and Dr. Clara Bakehouse are practicing together at 1615 Main Street, Columbia, S. C., and send best wishes for all.

Dr. Mary E. Alspach, Topeka, Kans., says in a letter enclosing the subscription for THE BULLETIN: "I do not want to miss any of the numbers. I always look forward to THE BULLETIN and Journal. They are like letters from home. Greetings to the Club girls."

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Dr. Minnie Schaub notifies us of her change of address to 5172 Vernon Ave., St. Louis, and sends wishes for the continued success of Axis members.

* * *

Dr. N. Maude Kellet encourages us when she says of THE BULLETIN: "If kept up to the present standard it is well worth the price and I anticipate no one will complain at the demand." We are trying to do our best to keep up the standard and believe Field members are glad to help us.

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Dr. Lorena Kagay, Marion, Ohio, sends best wishes for the prosperity of the Club and says she is very anxious to have THE BULLETIN.

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Word comes to us that Dr. C. DeGress McKinney has just opened an office in the Fourth National Bank Bldg. of Cincinnati, Ohio, and that she is very pleasantly located. She practiced for a while in Lebanon, Mo., but is glad to be in Cincinnati as her oldest daughter lives there and they can be together. She says in part: "Ohio needs osteopaths very much and we would be glad to have more come into the state."

* * *

Born, March 2, 1910, at Carlinville, Ill., to Edmund H. Parker, '10 and Nellie L. Parker, '08, a daughter—Mary Mabel.

THE BULLETIN extends congratulations and hopes that little Miss Parker will follow in the footsteps of her father and mother, and that some day she will be an Axis sister.

* * *

Dr. Eliza M. Culbertson, of Appleton, Wis., speaks of her summer plans as follows: "I am contemplating a trip to Europe for my next vacation so have been very busy reading what time I had for outside study. I am going with one of the Chautauqua Tours of which Dr. W. S. Naylor of Lawrence, College, Appleton, is president and also conductor of the tour which I will take. I will be gone three months, sailing June 11th from Boston. The parties are limited to twenty so we will have a fine chance to get acquainted with each member and expect to have the best of good times."

Dr. Mae Hawk Van Doren of Pittsburgh, says in a recent letter to the Editor: "I would miss my Bulletin more than any literature received. Dr. Geo. Laughlin's articles, alone are worth more than the price of THE BULLETIN per year, not speaking of the other valuable articles and news of class and field members which keep one in touch with the profession and which could not be done in any other way. I truly hope the Field members will heartily co-operate with the request on the subscription question. Best withes for success and good work of both Clubs."

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Dr. Carrie P. Parenteau, Chicago, sends kindest regards and best wishes to Club members and to the Odontoid Chapter and says in part, "My pin and club membership have meant a great deal to me."

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Dr. Almeda J. Goodspeed, of Chicago, writes in a letter containing subscription price: "I always look forward with pleasure to receiving THE BULLETIN. I send best wishes to the Club and all its members and hope it will continue long in its good work." Dr. Goodspeed also tells us that she has been a club member since '01 instead of '07 as printed in the Directory. We are sorry for these misprints and are glad to correct them when notified.

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Dr. Martha Petree sends THE BULLETIN and Club wishes for success from her home at Paris, Kentucky.

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A very interesting letter was read at the club recently from Dr. Mary L. Peery which was written while she was at Crystal River, Fla. Dr. Peery has been quite sick but wrote that she was getting better rapidly. Said she was living out of doors and spending a good deal of time fishing. She writes: "If I continue to improve in the art, I shall be able to tell fish tales equal, in incredibility, to any reports the osteopaths give of miraculous cures. When the spring time comes I hope to have some success catching patients. My office in Bristol had been open only two months but I made expenses from the first day and believe all would have gone well had I not fallen ill."

In closing Dr. Peery says: "Please remember that you always have my heartfelt wishes for the success of the club and its every interest."

Since receiving this letter we have heard that Dr. Peery expects to return very soon to Bristol, Tenn., and we hope she will be able to resume her practice and be as successful catching patients as she has been catching fish.

Dr. Emma C. Crossland, '06, of Grinnell, Iowa, recently spent a short time in Kirksville on her way home from a visit with her sister in Illinois. Dr. Crossland has been ill but is better and hopes to resume her practice in Grinnell.

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Dr. Johanna Young of Jersey City, New Jersey sends greetings to the Club. With regard to the fight in her state she says: "No doubt you hear of our great struggle just now in the State of New Jersey for osteopathic rights. I fear the outcome. It looks black but the clouds may clear away; it seems we must come out victorious."

Of course we will come out victorious in New Jersey as well as in other states. We believe, sooner or later, osteopaths will have their rights in all the states because we believe the osteopathic profession is on the right track. They may side track us for a little while but we're bound to get back on the main track and go straight ahead.

* * *

Wednesday evening, March 9th, the Local Chapter of the Club held its first open meeting of the term. The first number on the program was a solo by Miss Nickenig, after which the president, Mrs. Learner, with a few words of greeting to the new class, introduced the speaker of the evening, Dr. Bigsby, who gave us an interesting talk on Pathology and the use of the microscope in the diagnosis of disease.

Dr. Bigsby said in part: "It is becoming a growing custom among all who are interested in the healing of the sick to call on laboratory practice as an aid to diagnosis and to find the use of the microscope a great help. We believe that the time will come when a clinical examination will not be sufficient; but, to make a complete diagnosis, it will be necessary to take advantage of the knowledge gained by an intelligent use of the microscope."

The program was concluded with an instrumental duet by Miss Forrest and Miss Nellie Forrest.

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Friday evening, March 11th, the Club had a "dress up" party for club members, only. The evening's program opened with a grand march in which there appeared many whose faces seemed familiar but whose style of dress seemed strangely unfamiliar.

After the grand march we were treated to a highly entertaining and instructive performance by the "colored quartette" which convinced us, as nothing else could have done, of the great advantage one gains through a "higher education." At the conclusion of the piano solo by the most educated member of the quartette, several of the local

celebrities present made characteristic speeches (?) and refreshments were served by three wierd ghosts. The remainder of the evening was spent in an informal dance.

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Wednesday evening, March 30th, the new students were invited to the second open meeting of the term.

After a solo by Mrs. M. L Payne, Dr. Pratt, the speaker of the evening was introduced by the president.

Dr. Pratt spoke to us on the Principles of Osteopathy and said in part:

"A good many years ago Oliver Wendell Holmes delivered a graduating address at Harvard in which he made the remark: "You young gentlemen are going out with a keen feeling of your inefficiency. Remember this fact, that statistics show that 95% of those who are sick would get well any way." If he had said that 95% would get well in spite of their nostrums he would have stated the basis on which osteopathy stands, for the two ideas NATURE CURES and NATURE IS SELF SUFFICIENT made up the foundation on which Dr. Still built up the science.

NATURE IS SELF SUFFICIENT. Dr. Still was the first, if not the only one, who gave credit to the Creator, who said that man is a flawless product, that God has made man perfect, has not bungled in his manufacture, did not leave out essential parts.

The Old Doctor was the first one who said that man, as a machine, is perfect, that this machine obeys the laws of mechanics. Integrity of function depends on integrity of its parts. He claimed that this machine which has been created, this being, properly carries out all its functions when its various parts are in the right relation to each other. Therefore the proper person, the proper physician for the 5% who will not get well alone, is the one who finds the irregularity in the machine and corrects it.

THE CURATIVE POWER OF NATURE.

Because the Creator of this Machine is divine, He foresaw its future needs and arranged it so it would be self sufficient under ordinary conditions. An engine, to work properly, must have all its parts in working order, otherwise the machine works poorly. This human machine must do the same. However, it differs from the engine in the fact that the human machine is able to do its own oiling. Moreover, it is able to ascertain where the oil is needed, the particular kind of lubricant necessary and, within certain limits, it is able to repair wear and tear. It is a self-sufficient machine and is prepared and able to fix things up and prevent mal-function, to a certain extent.

We, as osteopaths, claim that this machine has within itself all the materials necessary for the prevention of tension, rust, etc., and as long as all the parts are in proper relation with each other the proper lubricants will be furnished and the fires will be kept burning. This, in fine, is the essence of the Old Doctor's teaching. He says: "The rule of the artery is supreme."

We know that all nutrition and waste products are carried by the blood stream. Therefore, just as long as the blood supply is normal in amount, and quality; as long as it carries the proper amount of nutrition and waste at the proper rate; as long as it is coming to a part and going away from it, normally, that part will be self-supporting, self-regulating, self-oiling.

How, then, is the human machine made conscious of tension, rust, etc., of conditions which if allowed to go on will cause trouble? By the nervous system. Every part of this machine is connected with this central nervous system. The part sends word of the condition to the brain and the brain sends out its commands. The machine is made up of parts which must properly function, the blood must carry the proper amount of nutrition and waste. The nervous system presides over these and sends the blood where it is most needed. So long, therefore, as the parts are in their proper relation there will be no disease. So long as the nerve supply is normal the orders will go out from the brain and the blood supply will be properly regulated. These then are the Principles of Osteopathy.

There are a few questions which we should now consider:

1. What is disease? We do not believe that it is some foreign monster coming in to destroy, but that it is merely a mal-function, an organ undergoing disturbed activity.

2. What is the cause of disease? If disease were a ravaging demon the only thing we could do would be to keep out of its way, but as we believe it is merely an interference with the proper function our duty is to remove the cause of the interference.

3. What is a lesion? A lesion is any perversion of structure which by pressure causes mal-function and interference with nerve and blood supply.

4. What is pain? Pain, according to other therapeutics is something to be combated. Osteopaths say it is an expression of Nature's activity showing that something is wrong. Should we give morphine to kill the pain thus shutting off the connection between the part where there is trouble and the central office? No. Pain is the sign that someplace along the way there is obstruction and killing the pain will not

remove the obstruction. You should know your anatomy and physiology well enough to be able to tell where to find this obstruction. It is most often found at the doorway to the central office. Therefore osteopaths most often treat the spine. You must not kill the pain which is an evidence of a hot box of the machine. You must not kill the evidence but remove the hot-box. The lesion is, therefore, the most important thing in your diagnosis.

5. What should be the nature of the treatment? The Old Doctor says you are a mechanic. You are supposed to learn the parts of the machine in normal position during normal function and you must know how to put them back when they have become abnormal. If you learn where the obstruction may be, look it up, and remove it. Nature will take care of the rest.

6. Finally, what is an Osteopath? It is a dangerous thing to give an opiate. Remember, YOUR FUNCTION IS THAT OF A MACHINIST.

Look for the defect. Remove the cause. If you can't remove it, entirely, help a little and may be Nature will do the rest. You, as osteopaths, can't do any better than to carry out the principles of Old Doctor A. T. Still. You can't all be surgeons, bacteriologists, or pathologists, but you all hope to be osteopaths. Remember, it is a good deal easier to give a pill than give a treatment, but the pill does not remove the cause. Work along your own legitimate lines and, though you can't cure all, you have a big field and you can cure a larger per cent than the others, for you go back of the symptoms and treat the cause itself."

LOCATIONS AND REMOVALS

Bakehouse, Dr. Clara, from Greenville, S. C., to 1615 Main St., Columbia, S. C.

Cosner, Dr. E. H., from Upper Sandusky, Ohio, to Dayton, Ohio.

Culbertson, Dr. Mary E., from 865 Superior St., to Post Office Bldg., Appleton, Wis.

Dunbar, Dr. R. J., from 401 Liberty Bank Bldg., to 720 E. Diamond St., North Side, Pittsburg, Pa.

Dwiggins, Dr. W. E., from Auburn, Calif., to Bakersfield, Calif.

Hansen, Dr. E. N., from 4514 Forbes St., to 315 Melwood St., Pittsburg, Pa.

Huffman, Dr. Thos. P., from 11 Wallace Blk., to 113 N. 6th St., Lafayette, Ind.

Marts, Dr. May, has located at Calexico, Calif.

McKinney, Dr. C. DeGress, from Norfolk Bldg., to Suite 507-8 Fourth National Bank Bldg., Cincinnati, Ohio.

Marshall, Dr. W. H., from Kirksville, Mo., to Vienna, W. Va.

Schaub, Dr. Minnie, from Carleton Bldg., to 5172 Vernon Ave., St. Louis, Mo.

Sims, Dr. Mary Lyles, co-partnership formed with Dr. Clara Bakehouse with offices at 1615 Main St., Columbia, S. C.

Spohr, Dr. C. B., from 114 W. Main St., to Masonic Temple, Missoula, Mont.

Thiele, Dr. F. G., from 324 to 321 Holmes Bldg., Galesburg, Ill.

Van Doren, Dr. Mac Hawk, from Allegheny, Pa., to 16 North Avenue, East, North Side, Pittsburg, Pa.