

was presented and accepted, and Dr. J. A. Dales was elected secretary.

Dr. F. C. Genung, of Wausa, was then elected to membership in the society.

Moved and carried that the WESTERN MEDICAL REVIEW, published at Lincoln, Neb., be the official organ of this society, and all proceedings of the society be reported to that journal by the secretary.

Moved and carried that there be an honorary list of members of this society, and that said members shall consist of dentists licensed to practice dentistry in the state of Nebraska.

C. E. Walden, dentist, Randolph, Neb., and F. C. Prettiman, D. D. S., Hartington, Neb., were then elected as honorary members of the society.

President Wilson extended an invitation to the society to meet at Hartington for the next regular session, January 5, 1897. The invitation was unanimously accepted. (There are four meetings per year—the second Tuesday of the month—January, April, July, and October.)

Adjourned.

A. F. MILLER,
Secretary Pro Tem.

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

Twenty-second Annual Meeting, Held at the Minnesota State Capitol, St. Paul, September 15, 16, 17, and 18, 1896.

[Concluded from October number.]

Dr. Hugh T. Patrick, of Chicago, read a paper on "Electro-Diagnosis and Electro-Therapeutics Simplified." Electro-diagnosis is limited to the affirmation or denial of a lesion of the lower neuron; that is, of a lesion of the motor cells in the spinal cord, or of the nerve fiber, the peripheral nerves springing from those cells. A lesion of this neuron causes the action of degeneration, and this, stripped of all unnecessary technicalities, may be recognized by two variations from the normal, namely a loss or very considerable diminution of faradic contractions, and the slow, wormlike contraction of the muscles to interruption of the galvanic current.

In the electro-therapeutics of organic disease of the nervous system, applications of electricity through the brain may be entirely discarded as useless. Electricity through the spinal cord is little better. In diseases of the peripheral nerves it probably hastens recovery, and that current is to be chosen which the better causes muscular contraction.

In functional nervous disease electricity is of more practical value than in organic affections, but it is almost impossible to determine what proportion of this good effect is due to mental impression—to suggestion.

The galvanic current is chosen for facial neuralgia, costal and sciatica. The faradic for lumbago, hysterical anesthesia, paralysis, and pain. The galvanic for exophthalmic goitre and some-

times for neurasthenic headache and backache. For facial spasms, tic, spasmodic torticollis, tremor, and chorea, electricity is useful aside from the mental effect.

The highly practical and otherwise unusual merits of the paper were touched upon in the discussion which followed, all agreeing in the verdict that the subject of electricity had been presented in a most practical as well as scholarly form by Dr. Patrick.

Drs. Larrabee, Hughes, Manley, and Stuckey participated in the discussion.

Dr. J. Frank, of Chicago, read a paper on the subject of "A New Method of Fastening the Round Ligament in Alexander's Operation, with Little Disturbance of Its Anatomical Relations."

An incision an inch long is made midway between the anterior superior spine of the ilium and the spine of the pubes, a trifle above Roupert's ligament. The transversalis muscle is pushed back and the ligament lifted out with a blunt hook, such as I here show you. Draw it out until the uterus is in the correct position. No great difference is experienced if the peritoneal cavity should be opened. Usually three sutures are required to close the wound, the first one being taken as low as possible through one flap of the peritoneum, then through the round ligament itself. Instead of drawing the ligament through the fascia, as formerly practiced, it is replaced in its anatomical position beneath the transversalis muscle. By this method a slough of the ligament is prevented. This operation is the simplest of all yet proposed for the purpose. As a suture material, kangaroo tendon has proven most satisfactory in my experience. A pessary should be fitted in before the operation, and worn as long as may be deemed necessary by the surgeon, afterwards.

Dr. A. J. Ochsner, of Chicago: Dr. Frank devised this method seven years ago. I consider it a great improvement in this operation, because it does away with tearing and injuring the tissues. His method leaves the organ in the best possible condition for recovery, with sufficient adhesions to protect the ligament from being drawn out again; yet without unnecessary adhesions. I have examined some of the author's cases and can confirm his favorable report.

Dr. J. Homer Coulter, of Chicago, read a paper on "Tonsillotomy by Cautery Dissection." No subject in surgery or medicine has been much more prolific in interest and discussion than that of the tonsil. In the past ten years over 600 papers have been written on that subject alone. The size of the normal tonsil is still a subject of discussion with throat specialists. Some claim there is normally no tonsil to be seen; however, the most usual opinion is that there exists normally a collection of follicles between the pillars of the fauces, protruding slightly above them. The tonsil is an almond-shaped gland, larger at one end than the other and somewhat flattened.

The methods usually employed for its ablation are the guillotine, igni puncture, the cold or caustic snare, or the knife. Each of these methods have practical objections to their use. Most important of these objections, and one which applies to all of them, is the fact that by no one of them can the gland be taken out. Unless this is done the part remaining will oftentimes produce as much trouble as did the former condition. The operation I propose obviates this objection entirely if properly performed.

With a well-heated small electrode the pillars are dissected away from the tonsil to one-half its extent. The gland is then, with suitable forceps, drawn well out and thoroughly and entirely dissected out to about one-half its extent. This portion is then cut off and the surface treated with a strong solution of silver nitrate. In a week or ten days the other portion of the tonsil is removed in the same manner. This operation will give cosmetic as well as practical results unobtainable by any other process yet suggested.

"The Surgical Treatment of Pyloric Obstructions," was the title of a paper read by Dr. W. J. Mayo, of Rochester, Minn. This subject has not received the attention it demands from American surgeons. The differential diagnosis of serious pyloric disease is often a matter of the greatest difficulty. I have found the free exhibition of strychnia for several days previous to the operation of great value in preventing shock. The stomach should always be thoroughly washed out a few hours before the operation and nothing eaten afterwards. For combating the shock, besides strychnia and dry heat, a rectal enema of a pint of hot coffee should be given. Nourishment by the stomach should not be too long withheld afterwards. For twenty-four hours rectal alimentation should be used; in thirty-six hours some champagne, later buttermilk, and a gradually increasing diet.

Dr. A. F. House, of Cleveland, opposed the use of the Murphy button and did not consider it the ideal method, as his experience had been somewhat unsatisfactory. I believe the less foreign matter one gets in the wound in uniting the bowel to the stomach, the better the result. I have discarded the button for the suture method. I believe much of the success in the use of the button depends on the skillful technique in using it. Perhaps I do not possess this skill.

Dr. F. F. Lawrence, of Columbus: In case of malignant disease we cannot promise more than temporary relief, and perhaps prolongation of life for a brief period. The simpler the operation the better for the patient. I doubt very much if resection in case of malignancy will give a permanent cure.

Dr. A. J. Ochsner: I should like to take away some of the good impressions the author has left regarding the hydrochloric acid test. I am convinced it is a most treacherous test. In suspected

carcinoma the best thing to do is to make a colostomy. In some twenty cases I have used irrigation of the stomach with decided satisfaction. In this way the patient will sometimes become well enough nourished to better stand an operation when it is desirable.

Dr. Thomas H. Manley, of New York, read a paper on "Conditions Which May Simulate Organic Obstruction of the Rectum." The author gave an extended, most interesting, and practical paper, putting new life and interest into the somewhat hackneyed, though none the less valuable, subject of constipation.

Dr. Norval H. Pierce, of Chicago, read a paper on "Submucous Linear Cauterization; a New Method for Reduction of Hypertrophies of the Conchæ." The author called attention to the various methods ordinarily used for the reduction of such hypertrophies, and showed the disadvantages of such. The differentiation between hypertrophy and turgescence was pointed out. The operation proposed by the author was as follows: A small incision is made in the hypertrophied membrane, then with a blunt flat probe the mucous membrane is carefully separated from the erectile tissue underneath. Then a sound, the end of which is cup-shaped, and upon which has been fused a few crystals of chromic acid, is inserted in the incision and the track already made by the probe is thus cauterized. The advantages of this method are that there is no hemorrhage. It is less painful than by any other method. The functional activity of the mucous membrane is not in the least impaired. Patients will submit to this operation more willingly than to the burning of the cautery. The method is the most simple of any yet suggested. The reaction is usually insignificant. There is no slough. The danger of atresia is obviated.

Dr. Horace H. Grant, of Louisville, delivered the address on surgery. He selected for his subject "The Relationship of Diagnosis to the Future Surgical Progress." Some common ground must be chosen on which we can equalize our differences. Many of the most recent operations are already passing away under the effect of our modern scrutinizing investigation. We forget there are men in the quiet of their laboratories doing a work which makes all our wonderful progress possible and gives us these new methods. We cannot progress much farther in technique or operative skill. Any great amount of paraphernalia suggests a lack of personal resources in the operator. Almost every part and organ of the human body has been removed, recently, with more or less good to the patient. If we would make earlier and more careful diagnoses many of the possible failures would be precluded. No surgeon dare say to the patient, "If I had known yesterday or before, thus and so, the result would have been different." Are we not at fault sometimes ourselves? Rarely will we fail to secure an operation if the operator be

certain of his diagnosis and demands the operation.

No term in all surgery is so often misapplied as conservatism. No aim is dearer to the surgeon than the ways and means of relieving his patient. We must not fall into the error of making one man great and another insignificant. The experience which age gives some men leads them to make valuable and correct diagnoses. Experience is, and should be, one of the greatest aids in diagnosis.

The skiagraph has lately come into importance in surgical work, and it may be made an excellent adjunct in many instances. Its recent successes are noteworthy. It is yet, however, in its infancy, and doubtless is capable of still more development. May we not soon expect to see the fetus *in utero*? No one doorway can open to the royal road to success in the practice of surgery. The skillful and intelligent application of prompt relief, added to a careful diagnosis, will give us the most wonderful and satisfactory results.

What each one finds to do, let him do it with his might.

An unanimous vote of thanks was extended to Dr. Grant for his scholarly and interesting address.

Dr. James H. Dunn, of Minneapolis, read a paper on "Appendicitis: To Operate or Not to Operate." If we could but foretell which of our cases were going to be fatal, we could much more easily and satisfactorily decide this question. The percentage of fatality is yet too high. Yet must we cease operating because of such fact? A certain number of these cases will recover without surgical interference. Indeed, there is so large a number of such that I believe we very often, in our enthusiasm, operate when it would have been much better to have left them alone, so far as the knife was concerned.

Dr. J. B. Murphy, of Chicago: The surgeon is brought face to face with a condition which has a recognized mortality of about five to eight per cent. I think such a percentage is too high. We first have to contend with the presence or absence of a suppuration. In 450 cases I do not think there has been an entire absence of pus in one single instance. I am satisfied there are some cases which can be cured by medicine, but can they be differentiated? By medical treatment we have a mortality of ten per cent, and if we have three per cent by the knife, then we must operate to save the other seven per cent. I don't think every case can be operated upon, but the conditions will show whether or not it is advisable.

The next paper was that by Dr. Gustave Fetterer, of Chicago, on "Pleuritic Effusions and Their Treatment." A bacteriological examination should be made in all cases; both with cover glasses, with culture media, and by injections of the effusion in animals. Distinguish between exudate and transudate by using the acetic acid chemical test; and by the same process eliminate

mucine. Many cases of pleurisy are of an uric acid diathesis. These will yield readily to the treatment by the salicylates. I believe not more than fifteen per cent of pleuritic cases are rheumatic. The finding of pneumococci does not aggravate the conditions, and often gives no markedly distinct symptoms. Pleurisy in typhoid is not a mixed infection, but a distinct condition. Tubercle bacilli are often found in the pleuritic effusions. I believe it is not only possible, but likely that the tubercle bacilli do penetrate through the alveolar septi and enter the pleura without producing infection in the lungs. Tuberculosis may be differentiated by the agar culture. Hyperesthesia of different parts is frequently present. I have washed out the cavity in fourteen cases with an antiseptic solution of one-half to two per cent of clove oil, with most gratifying results in twelve of the cases. The advantages of this method are: Many patients will allow such an operation who would object to an excision of the rib; no bulky dressings are constantly interfering with the comfort and convenience of both patient and physician; much shorter time is required.

Dr. A. J. Ochsner, of Chicago, read a paper on "Nerve Sutures and Other Operations for Injuries to the Nerves of the Upper Extremity." My own observations and a study of the literature lead me to a confirmation of the following conclusions:

1. Every severed nerve should be sutured, even after years.
2. The earlier the operation is performed the better.
3. If neither sensation or motion is established within a year, the nerve should again be exposed, the cicatricial tissue removed, and the end again sutured.
4. The end should be clean cut, should contain neither crushed tissue nor cicatricial tissue.
5. Tension must be avoided.
6. The wound must heal without suppuration to secure the best results.
7. Hemorrhage should be perfectly controlled to prevent intervening clot.
8. Carefully prepared catgut is the best suture material.
9. After suturing the ends either direct or "a distance," it is well to stitch a fold of fascia over the united nerve ends.
10. The extremity should be placed at rest.
11. The external incision should be ample.

Dr. Henry P. Newman, of Chicago, read a paper on "Woman and Her Diseases vs. Gynecology." We are coming to a period of transition in the practice of surgical studies on the cure and prevention. Preventive medicine, hygiene, sanitation, and sociology are now popular themes for medical societies. Philanthropy has taken the cue from medicine, and is attempting to form a citizen rather than reform him. I wish to emphasize the fact that we are not dealing with the cold science side of our art, but with the highest of humane interests. The amount of ignorance in the

average woman of nature's requirements is appalling. Woman's sphere has lately widened until now it is as wide as man's. Has she equipped herself for this race intelligently? Look at the average woman in the cities; the average stenographer, saleswoman, the business woman, do they not daily outrage their bodies by compliance with the dictates of fashion in food, dress, and habits?

The tendency of gynecologists to enter surgery is to be deprecated. It narrows his opportunities. He had better stay attached to obstetrics and pediatrics. A woman's generative organs should not be doomed because she has needed to visit the gynecologist. A good diagnostician must know as much about women as about disease; as much about environment and social and domestic relations as about pelvic lesions.

As specialists we must recognize and exercise the important interests in a medical science which still prevent, rather than cure, disease. As we know what can be acquired may be prevented, hence we as specialists should lead in the reform of those conditions which are detrimental to the health of woman.

"The Pathology and Treatment of Suppurative Salpingitis," was the title of a paper read by Dr. F. F. Lawrence.

The tubal mucosa is a true mucous membrane, possessed of all the histological elements of mucous membrane. The fimbriæ are prolongations of the folds of mucous membrane, with a few muscular fibers beyond the end of the tube.

The closure of the end of the tube is effected by—first, the unfolding of these plicæ and the elongation of the muscular fibers, with coincident inflammatory exudate, and not by adhesions of the peritoneal surface. Second, the formation of adhesions between the fimbriæ and other structures. Third, embedding of the fimbriæ in inflammatory exudate.

The closure of tubal ostia results in forming of circumscribed abscess; the pathology of which is the same as that of suppuration, with abscess formations, in mucous membrane in other parts of the body, except for its effect upon important contiguous tissues. Occasionally the uterine end of the tube, communicating with the uterine cavity, through which it may in part discharge its contents.

TREATMENT.—The treatment of pus tubes cannot be fixed by any ironclad rule. Each case must be treated according to the conditions there presented. We must even incise and drain in some cases. Seldom will vaginal section be required, and only in carefully selected cases. Hysterectomy is indicated in those cases where we find abscess of the uterine wall, tuberculous deposits, fibroids, or malignant disease in the fundus. As hysterectomy destroys the pelvic floor, it should never be performed except where there is some tangible lesion of the uterus. Abdominal section will be necessary in many cases.

"On the Importance of Physical Signs Other

Than Murmur in the Diagnosis of Valvular Disease of the Heart," was the title of a paper contributed by Dr. James B. Herrick, Chicago.

Standard text-books teach that an endocardial murmur is not always an evidence of a valvular lesion, and also that a valvular defect may exist and still no murmur be present. Practically, however, conclusions are usually based upon the presence or absence of murmur. This is wrong, for there may be a valvular disease without a distinct murmur being audible. Other findings than murmur must be used in determining the existence of a valvular lesion. Every valvular lesion must result in hypertrophy and dilatation of the heart behind the valve diseased. An increase in tension of the pulmonary circulation follows any valvular lesion at the mitral orifice, and later any aortic disease. This will show in increased force of the pulmonary second tone.

Stenosis of the orifices of the left heart means a smaller amount of blood in the general arterial circulation, therefore, lessened arterial tension.

Failure of the right heart is followed by venous congestion, *c. g.*, venous pulse, hepatic and portal congestion, anasarca, etc.

Hypertrophy may be recognized by the heaving, forcible apex impulse. Epigastric pulsation may call attention to enlarged right heart. The jugular pulse, the hepatic and capillary pulse, are all of diagnostic value. The visible pulse or aortic regurgitation is almost pathognomonic.

Palpation is important. Extra-cardiac causes for murmur, such as might arise in a heart dislocated by pressure or retraction, can usually be excluded by percussion.

A weak aortic sound may be an indication of obstruction. The reduplicated second sound may point to valvular disease. A sharply accentuated first sound at the apex is common in mitral stenosis. The peripheral tones in aortic regurgitation are a valuable confirmation.

Cases illustrating the foregoing were referred to.

Error in calling an inorganic murmur organic is readily made unless the secondary sounds are carefully sought for. The intention of the paper was not to undervalue the importance of endocardial murmur, but to insist that it is only by the complexus of signs and symptoms that an accurate diagnosis can be made. Of all the evidences of heart disease, the least valuable is the endocardial murmur.

Dr. R. H. Babcock, of Chicago, read a paper entitled "A Report of a Case Illustrating the Value of Secondary Physical Signs in the Diagnosis of Cardiac Diseases." Among other points brought out were: Murmurs are the least reliable signs of valvular disease. An accurate diagnosis cannot be made unless the secondary signs of valvular disease are recognized. If the heart actions are not sufficiently strong there may not be any murmur; or a grave defect may not be observed for the same reasons. Secondary symptoms are a modified pulse rate, character and rhythm, leading

to a congestion of the veins and internal organs. In some instances there is also systolic venous pulsation of the liver. Such systolic jugular pulsation is diagnostic of insufficiency, even if the murmur is not audible.

Dr. I. N. Love, of St. Louis, read a paper entitled "Water." Drugs, drugs, drugs, seemed to be the chief inspiration in the life work of too many men. Hydropathy has been a wonderful service to humanity. We can appreciate the necessity of water when we remember that seventy-five per cent of our body is made up of water. It is just as important as the solids in life's conditions. The demands for water are affected by the amount of muscular exercise and degree of temperature to which the body is exposed. For an irritated stomach or bilious colic nothing is superior to liberal quantities of hot water. For "a night out" two or three cups of hot water along with a cup or two of hot coffee nothing is superior. It soothes the nervous system if you will abstain from food a few hours.

We need water for nutrition, but also as well, and more important, for a proper elimination. Water taken freely acts as a purifier of the system, both by flushing and by its solvent action. The majority of people drink too little water. I would highly advise training children to drink more water. It is a most important agent in improving the complexion. Medicine should be given in large quantities of water. In typhoid fever I insist upon free drinking of pure water. No solvent will act better in removing uric acid from the system, and the only pure water is distilled water.

Copious draughts of water for its stimulating effect or the reduction of temperature has been used many years. The hot pack in convulsions of children is often misused. Better begin with a tepid heat and add cold water gradually. Hot water locally in inflammatory conditions is most excellent.

Dr. Isaac A. Abt, of Chicago, read a paper, "The Clinical Significance of the Child's Fontanelle." In health the fontanelle does not sink below or rise above its bony frame. It has both respiratory and pulsatory movements. With increased intracranial pressure and normal bruit may quite disappear. An early ossification interferes with brain development and produces a brachycephalic skull. In rachitis the involution of the fontanelle is delayed. Marked bulging is caused by the collection of fluid within. The abnormal retraction of the fontanelle always indicates a condition of inanition. It may be temporary; if chronic it is a serious condition. A deeply sunken fontanelle is always a danger signal in any case. Involution occurs normally at fifteen to eighteen months. Protuberance and tension indicate meningitis.

"Operative Treatment of Pterygium," was the title of a paper read by Dr. Eduard Boeckman, of St. Paul. The author discussed the history of the operations for the cure of pterygium; pointing out the objections as well as the advantages of those

most frequently used. He suggested an operation which was a combination of some others referred to. A crescentic piece is cut from the pterygium about five lines from its head. This part is curetted thoroughly down to the sclerotic. The head of the pterygium is dissected off. At the convexity of the piece cut out a stitch is inserted and the opposing edges drawn together. This leaves the curetted portion to granulate and form a cicatrix. The author thinks the results from this method superior to that of any other in his experience. The paper was discussed by Drs. Wilder and Buckner.

Dr. William H. Wilder, of Chicago, read a paper on "Subconjunctival Injection in the Treatment of Certain Diseases of the Eye." The method consists in the injection beneath the conjunctiva of minute quantities of bichloride of mercury or cyanide of mercury in solution. The operation is not especially painful unless there be inflammation present. It has been advocated for many other conditions and diseases. Its exact limitations and indications are not yet positively decided upon. It has been impossible to get the same good results from the salt injections that can be obtained from the mercury. We have in this new treatment a powerful adjunct to the old and tried methods in some diseases of the eye. It is not to be employed to the exclusion of all others. It is not a panacea, but in indicated cases for the mercurial treatment it is an excellent method.

Dr. James H. Buckner, of Cincinnati, read a paper on "Rupture of the Choroid Coat." The length of time which elapses from the date of the accident and impairment of vision is no criterion by which to judge of the amount of damage done to the choroid. The rarity of rupture of the choroid is due to the elasticity of the coats, together with the soft and elastic cushion of fat upon which the eyeball is supported.

Dr. W. S. Caldwell, of Freeport, Ill., read a paper on "Ether and Chloroform; Their Comparative Merits as Agents for the Production of General Anesthesia." The author gave an extended résumé of the statistics of death from chloroform and ether, giving his preference for chloroform and the reasons therefor.

Dr. C. B. Parker, of Cleveland, Ohio, read a paper on "The Use of Oxygen in Chloroform Narcosis." The exhibition of the vital principle, oxygen, with chloroform would seem to be proper on theoretical grounds. In uniting the two there is no chemical union formed between them. It is a mechanical mixture such as we have in the air. The oxygen must be perfectly pure. That usually supplied in tanks is not pure. It must be properly made. The cylinder must have been exhausted of all air before it is filled. The time required to anesthetize is slightly longer than with chloroform, but the advantages far outweigh this minor inconvenience. Of the dangers attendant I am not prepared to say, as I do not consider an experience of 118 cases guarantees any statement relative to

that point. There is total absence of vomiting, as well as absence of the extreme pallor and weakened heart beats, with shallow respiration. The duration of the shock from anesthesia is with this agent very much shorter. The patient always recovers promptly, without any delirium.

Dr. C. Travis Drennen, of Hot Springs, Ark., read a paper on "Syphilis as an Etiological Factor in the Production of Tabes Dorsalis."

Dr. W. F. Barclay, of Pittsburg, read a paper on "Diseases of the Nose and Throat in Children." The author dwelt particularly on the possible results of acute and chronic purulent and mucopurulent rhinitis in children, pointing out not only the necessity for more attention by the family physician, but as well demonstrating that almost if not all of the pathological conditions in the nose occurring later in life have their origin in this condition in childhood. The paper throughout was an unusually practical and interesting one. Practical because we see it daily demonstrated in our professional life. Children should be taught to breathe through the nose rather than the mouth. Parents should be taught that surgery can relieve, very easily, those who are unable to breathe through the nose.

"Surgical Melange" was the title of a paper read by Dr. J. Merrill Ricketts, of Cincinnati.

I. Ligation of brachial artery. Secondary hemorrhage occurred six days after an accident. Five days later another severe hemorrhage occurred. The middle brachial artery was ligated at that time. Six days later a third hemorrhage occurred. Erysipelas followed and recovery was uninterrupted. The superior profunda and its branches were the source of the hemorrhage after the ligation of the brachial. The ligatures should have been applied above the superior profunda.

II. Gunshot wound dividing the facial artery. Roller compresses were sufficient to control the hemorrhage. Multiple abscesses appeared on the cheek subsequently, one of which left a salivary fistula. This fistula was finally closed by the introduction of a silver wire.

III. Talipes equinus varus of left foot, with external deformity. Phelps' operation had been made one year previously, with but slight improvement. The astragalus was removed, five weeks later, through the dorsum of the foot. Division of the tendo-Achillis was not necessary.

IV. Hypertrophied prostate. On the twenty-fifth day of a severe attack, double orchidotomy was done under cocaine anesthesia. I have found cocaine will answer every purpose in these cases. This was the third case in which the same operation had been done; all were successful.

V. Sarcoma of the sacrum. There was present a syphilitic diathesis. It had been previously diagnosed as a fatty tumor. Complete removal was followed by a prompt recovery, leaving a fistula from the rectum into the cavity. This was successfully closed by a later operation.

Papers were also read by Dr. Fenton B. Turck,

of Chicago, "Further Report on the Treatment of 500 Cases of Gastritis;" Dr. Casey A. Wood, of Chicago, "Some Rare Forms of Keratitis;" Dr. A. E. Stearne, of Indianapolis, "The Significance and Occurrence of Capillary Pulsation in Nervous Diseases;" and by Dr. G. I. Cullen, of Cincinnati, "The Newer Remedies in Otolology and Their Results."

AMMONOL IN THE COURTS.—A motion was argued in the supreme court before Justice Pryor, August 21, in an action brought by Dr. Cyrus Edson, late of the health department, against the Ammonol Chemical Company, of New Jersey, and Dr. Allen H. Still and F. W. Stemmler, in which he asks that Still and Stemmler be enjoined from making or further selling a preparation made by the company, and for the abrogation of a number of contracts that he made with the two defendants, charging that they have defrauded him out of an interest in the company, and have failed to carry out their contracts.

It appears that in 1892 he, with Still and Stemmler, the former a physician and the latter a commission merchant, entered into a contract, under the terms of which a stock company was to be formed for the manufacture of Ammonol and its sale to physicians. Stemmler was to furnish capital and push the sales. Still was to boom it among physicians, and Edson was to furnish the formula, and also to use his influence to have the preparation adopted. Stemmler got sixty per cent, Still twenty per cent, and Edson twenty per cent of the stock.

As stated by Edson's lawyer, Dr. Ullo, Dr. Edson, through motives of "professional delicacy," did not care to hold stock or figure openly in the scheme, so he agreed to surrender his twenty per cent of stock for a one-tenth interest in the dividends of the company. He now contends that it is this interest out of which he has been defrauded by the conspiracy of the defendants, Still and Stemmler, who, he says, to further their conspiracy, have voted to themselves salaries of \$3,000 and \$2,000 a year respectively, and have tampered with the books and papers of the corporation.

Dr. Pincoffs, representing the defendant Stemmler, referred sarcastically to Dr. Edson's "professional delicacy." Justice Pryor was plainer. He said:

"The whole amount of the matter is that Dr. Edson was willing to take his profits from a quack medicine."

"Oh, no, your honor," cut in Dr. Pincoffs; "it is not a patent medicine; it is a very good thing."

"Well, at any rate," said the court, "he was willing to appear indifferent to the sale of the preparation, while he was really talking it up to the profession for his tenth interest."—*American Druggist and Pharmaceutical Record*.

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