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WESTMINSTER SUNDAY SCHOOL HOSPITAL, CHANGEH, HUNAN
ON THE FINAL RESULTS OF HYSTEROPEXY.

By JAMES L. MAXWELL, M.D., TAINAN, FORMOSA.

Surgeons in China have often remarked to me on the difficulty of following up their cases owing to the vast areas from which their patients are drawn and the lack of good travelling communications. In respect to the latter, we meet in Formosa with no such difficulty, and the careful registration of all householders by the Japanese authorities, makes it comparatively easy to trace our patients long after they have left us. I have lately made an effort to follow up the final results of certain surgical procedures, and it has been suggested to me that the results of my search may be of interest to our colleagues on the mainland. I therefore propose to embody them in a few short papers beginning with this one on twenty-five cases of hysteropexy.

These cases date back from a little more than a year to about fourteen years, and have been mostly operated on by myself. Some of the more recent ones, however, have been treated by my colleague, Dr. Gushue-Taylor.

Cases of uterine prolapse are very common among the Chinese and cause a varying amount of discomfort. Many of the patients are averse to any operative treatment, but enough have come under our care to enable us to form some opinion as to surgical treatment and its results. To the use of pessaries as a means of uterine support in the Chinese, I am utterly opposed. Among the poorer classes in the West it is seldom that they can be regarded as anything but a very dirty method of treatment, while out here, where it is unlikely that a douche will be used as directed, and where it is extremely difficult to persuade the patients to attend the clinics with any regularity, they should be very seldom, if indeed ever, used.
Certain objections have been raised to the operation of hysteropexy on account of dangers which are supposed to follow this method of treatment, viz., dystocia in case of subsequent pregnancies, and intestinal obstruction from strangulation round the attached uterus. The number of cases given here is not sufficient to exclude such possibilities, but they are enough to suggest that these must be extremely rare and are possibly due rather to faulty technique than to the operation itself. The mortality of the operation has been nil, and indeed its dangers are not greater than those of many minor operations.

Details of Operation. The patient having been prepared in the usual way and anesthetised, the uterus is replaced if completely prolapsed, and by means of a uterine sound passed by an assistant is held up against the anterior abdominal wall where, as a rule, it can be easily palpated by the surgeon. A median sub-umbilical incision about two inches long is then made over this, and the peritoneal cavity opened. The uterus is caught by volsellum forceps and a guide suture passed well into its substance just below the middle of the top of the body. The forceps are taken off, the sound withdrawn, and the guide suture handed to an assistant who pulls it up into the upper extremity of the wound, thus bringing the front of the body of the uterus into the wound. Three suspensory sutures are now passed. Each enters the skin about two inches or more away from the edge of the wound, traverses the muscles but not the parietal peritoneum, passes deeply through the front of the body of the uterus, and then through muscle and skin to a corresponding point two inches or more away from the opposite side of the wound. The uppermost of these sutures is thus well below the summit of the uterus. They are left loose until the close of the operation. One suture is now passed through the upper angle of the wound, going through the whole thickness of the abdominal wall including the peritoneum. This closes the peritoneal cavity at the top: it is tied at once. Skin sutures are next put in for the rest of the wound. Finally, the assistant still holding the uterus up by means of the guide suture, the suspensory sutures are fixed. I prefer to do this by means of suture buttons. If preferred they may be tied over rubber tubing. In my earlier operations I tied them without such precautions with the result that I was always having trouble with my skin edge from which the blood supply had been mostly cut off by the tying of the suspensory sutures. Fixing with suture buttons obviates this trouble. When these sutures are fixed the guide suture is cut and pulled out, and a lint tampon is placed in the vagina for 24 hours.
On the Final Results of Hysteropexy.

I consider two points in this operation of special importance. First, that the suspensory sutures pass through the front of the body of the uterus below the summit. There is then no tendency to displacement, or irregular growth of the uterus when pregnancy occurs. Second, that no permanent sutures are left in.

The skin sutures are removed at the end of a week or ten days, the suspensory sutures after a fortnight.

Among the twenty-five cases there was one operative failure,—a case complicated by cystitis in which the constant straining prevented the uterus getting proper adhesions. It came down again before the patient left hospital, practically as soon as the sutures were removed.

One case could not be traced.

This leaves twenty-three cases to be considered. Of these, twenty-one cases have proved permanent successes. In two cases the condition has recurred.

In one of the latter cases, the patient developed a chronic cough and it may be that the recurrence was due to this. In the other, a very rapidly growing spleen seems to have forced the uterus down again. Thus of these twenty-three cases, roughly 91 per cent are permanent successes, and 9 per cent failures.

All these twenty-three cases were within the limits of the child-bearing period. Indeed, several of the patients wished for operation in the hope that replacing the uterus would give them more chance of further pregnancies. Of the twenty-one cases that have not recurred, ten women have become pregnant and collectively have borne thirteen children. The children have all been born alive and without difficulty. Eleven women have had no children but, with the exception of two who were aged 41 and 42 when operated on, these are all cases of comparatively recent date.

Of the ten who have borne children the average time since operation has been five years; one was operated on eleven years ago.

It will be seen that we have not made it a rule to do an additional colporrhaphy, as commonly recommended, and the results here obtained show, I think, that this is quite unnecessary. Especially is this borne out by one of our cases, which, for another reason also, is worth recording. A woman, aged 38 years, came to the hospital suffering from complete procidentia uteri. The organ had been outside for fifteen years, and for many years owing to its increased bulk from congestion the woman had been unable to replace it. The vaginal walls were greatly stretched and there was much ulceration of the dependent part. The patient was kept in bed with the buttocks raised and the mass was
firmly bandaged. This reduced the size considerably, but it was still impossible to replace it. After a week or two it seemed improbable that a continuation of the treatment would further reduce the bulk, so operative measures were undertaken. Under the anesthetic, after a great deal of manipulation, I succeeded in returning the uterus, and the operation as described above was carried out. Convalescence was uninterrupted but the patient complained of a good deal of pain, probably from the tearing of adhesions. When the woman left hospital the uterus was in good position, but there was marked sagging of the relaxed vaginal walls of which the patient complained. Now, three years later, there has been no recurrence of the prolapse and the patient no longer complains of the dropping of the vaginal wall. No doubt, with time, and the relief of congestion, these have regained their normal tone. I record this case, not only because of the success of the treatment, but because I was greatly tempted to solve the difficulty by removing the uterus when I found that replacement was so hard.

The danger of such an operation was brought home to me a few weeks later when a patient came for treatment of a prolapsed bladder following on removal of the uterus for procidentia. The operation had been done in a Japanese hospital for a simple prolapse without the excuse I should have had of many years' irreducibility. The woman was in a miserable condition; the bladder had completely prolapsed with the anterior vaginal wall, and she was far more uncomfortable than if the original condition had been left untreated. In this case I fixed the top of the bladder to the abdominal wall and temporarily relieved the condition, which, however, recurred in a few months' time. She then came under the care of my colleague, Dr. Gushue-Taylor, who repeated the operation and further did an extensive colporrhaphy with excellent and probably permanent results.

**A CASE OF ADVANCED INTRA-ABDOMINAL PREGNANCY.**

By B. RANDALC VICKERS, M.B., Wuchow, Kwangsi.

In view of the rarity of abdominal pregnancy continuing to the later months it is worth while recording the following case recently treated in Wuchow, Kwangsi.

P'aang Ts'ii-shi (彭秀氏), boatwoman, aged thirty-nine, appeared at the clinic on November 23rd, 1915, complaining of a lump in the abdomen, and giving the following history. "Fever and chills in the fourth moon: swelling of abdomen began a month ago: occasional
pain in abdomen: bowels open daily with hard stools. Menstrual history: had two children nineteen and twenty years ago, no pregnancy since then: the menses were regular until the third moon of this year (April-May), then nothing until sixth moon (July) when the flow appeared twice: the same happened in the seventh moon, since when nothing up to date. Premenstrual pain for about a year: no vaginal discharge."

**Abdominal Examination.** A visible tumour in lower abdomen roughly median in position. Faint linea nigra present, also a number of cautery marks in the left iliac region, which part she says is the most painful. The tumour comes up from the pelvis, is irregular, moveable and very hard, manipulation causing more or less pain. Percussion dull: splenic area resonant. The upper limit of the mass is about at the level of the umbilicus, and an "edge" is palpable to the left of this.

**Vaginal Examination.** Great hypertrophy of lips of cervix, which is very soft. There is a knob in Douglas' pouch, very hard, and connected with the abdominal lump. The uterine sound passes 4½ to 5 inches. The main mass seems to be behind the uterus, which is deflected towards the right side.

The patient was admitted to hospital on November 29th, 1915. After admission she had a good deal of pain in the tumour, and six days after coming in began to have a pale, bloody discharge from the vagina (menses?). On December 7th she passed three fleshy "clots," one of which I saw, which was an inch and a half square, and three-eighths of an inch thick, not unlike decidual membrane.

On December 8th, 1915, the following note was made: "On examination of abdomen this morning I noticed immediately that the mass was moving inside in a manner suggestive of vigorous fetal movements. These continued incessantly, and further examination showed that the irregularities of the tumour might well be fetal small parts. Careful auscultation revealed a fetal heart beating at 168 per minute, heard in the left iliac region immediately above and external to the innermost of the cautery marks. Patient says the tumour has been moving for over a month, and the movements are accompanied by pain."

On December 10, 1915, it was noticed that the "upper part of tumour is to-day well above umbilicus: cannot define it well because of the tenderness and cannot make out the placental mass."

On that day with the assistance of Dr. Hayes I operated; Dr. Leavell gave chloroform. Incision in middle line above and below
umbilicus, five inches long. As soon as the peritoneum was incised, intestines presented and omentum, and a certain quantity of yellowish fluid escaped. The intestines had lost their gloss and were studded in parts with little nodules from a chronic peritonitis; they were not matted together, though here and there flakes of lymph were seem. While the bowel was being replaced a loop of umbilical cord extruded itself from the lower end of the wound. On holding apart the abdominal wall the child was visible, and was extracted without much difficulty, the head causing a little delay as compared with other parts. The position was dorso-anterior with feet in right false pelvis, and head up in the direction of the spleen. The child was not in any sac, but the head was enclosed in a pouch which seemed to grasp its neck and caused a moment's delay in delivery, though there was no definite membrane found. The cord, having been clipped and severed, was traced into the placenta, which was found to be large and attached to the right side of the pelvis and the posterior surface of the uterus. In view of the risk of serious hæmorrhage from the placental sinuses it was decided to remove the uterus and appendages en masse with the attached placenta. As the uterus had also a myoma this proceeding was less undesirable than it might otherwise have been. Supravaginal amputation was therefore performed with the removal of the right appendages and left tube; the left ovary being left in situ. Considerable hæmorrhage was encountered from the placental vessels, as the tissues were more friable than is the case with normal intrauterine placenta. As the patient had lost a good deal of blood and the general condition was dangerous, no attempt was made to unite the opening in the posterior parietal peritoneum. This was because the previous manipulations in this area had led to much bleeding and it was feared that the introduction of the needle for stitching might restart the trouble. A tube and gauze drain were left down to the bare area, and the anterior abdominal wall closed. The operation took three hours exactly, and at its close the patient's pulse had recovered somewhat, and was fairly strong, at 116 per minute.

The child was covered on its back, shoulders and arms with lanugo, being apparently about eight months old. It was revived after delivery and lived for a few hours: sex, female.

On examination of the extirpated uterus, etc., it was found that the right tube could be traced for a distance of about one inch and was then lost on the placenta. The placental attachments to the womb's posterior surface were of such a nature that they could have been broken down without severe hæmorrhage, but previous to the removal
it was impossible to know this. The uterine cavity contained a ragged decidua, and in its anterior wall was an interstitial myoma the size of a walnut. The right ovary was enlarged. It is noteworthy that the child was to all intents free in the peritoneum without any enclosing sac of amnion and not surrounded by any appreciable amount of fluid.

Thirty-six hours after operation the temperature rose to 103.2° F., and peritonitis threatened. This was not surprising in view of the manipulations and the large bare area. By proctoclysis and hypodermoclysis, however, the danger was averted, and the untoward symptoms gradually disappeared. The subsequent progress was good, but complete closure was delayed by the infection of some deep ligatures which necessitated continued drainage. Ultimately the patient left hospital completely well on January 27th.

It is interesting to note that on December 24th to 27th the breasts enlarged and became knotty, with secretion of a watery milk.

Reconstructing the history of the case, it appears that the patient became pregnant about the third moon, the pregnancy occurring in the right tube. Amenorrhœa followed, but by the sixth moon the sac had grown large enough to require more space and ruptured the tube: this was accompanied by uterine hæmorrhage. The internal hæmorrhage was not very severe and though the sac itself was ruptured, that part of the chorion which was destined to form the placenta was not damaged sufficiently to overcome its vitality. The embryo continued to grow, the placenta forming around the site of rupture.

The foetus was in the nature of a foreign body free in the peritoneal cavity, and set up a chronic low peritonitis, as evidenced: (1) pathologically, by the granular intestinal peritoneum and free peritonitic fluid, and (2) clinically, by the tenderness on palpation and pain on foetal movements. (There is no reason to suppose that intraperitoneal foetal movements, apart from inflammation, would of themselves cause pain, any more than the physiological movements of intestinal loops cause pain in normal individuals.)

The irregular hæmorrhage in the sixth and seventh moons is thus accounted for. The passage of decidua while in hospital may not unreasonably be attributed to the exploration by sound a few days previously. In fact it seems as if a 'labour' had supervened but that the placental circulation had not immediately ceased, as is usually the case.

The question which I have not been able to solve is, why should the foetal movements have varied so greatly at different times? When I saw her in the dispensary and again in hospital, abdominal inspection and palpation aroused no suspicion; but on December 8th, the moment
the abdomen was uncovered one could not help seeing the furious "kicking" continually going on: and yet, having seen and felt the movements, the next day, on prolonged palpation, I failed to detect any movement whatever, though the event proved that the child was not dead.

A GYNECOLOGICAL DISPENSARY IN KOREA.*

By Rosetta Sherwood Hall, M.D., Pyengyang, Korea.

During the past quarter of a century there has come slowly but surely a great change in the kind of disease and the character of the patients who frequent our dispensaries for women. Formerly, only low-class women came and largely for surgical relief: then they found out we could treat eye, ear, and skin diseases, and extract teeth better than the native doctor. It took longer for them to believe that our drugs were superior to their own for internal medicine, or that the Western physician could understand the internal anatomy of a Korean. From the first, however, we were called to the homes for all varieties of abnormal obstetric cases.

Gynecological cases were apparently so rare that it almost made us believe that Korean women did not suffer so much as others from "female complaints." But within the last decade the change has been marked. Women of the middle and higher classes now come to our dispensary. Even the wives of officials await their turn with the low-class women. And we find all the varieties of gynecological troubles of the home lands, with a few in addition due to the results of native forms of treatment that our specialists never see.

In point of number, these cases used to rank 6th or 7th in the eight divisions we make of our dispensary patients. About the year 1900, the medical cases had already for some time exceeded the surgical, with ophthalmic and cutaneous cases following closely; then came aural, gynecological, dental, and nose and throat cases. In 1905, the gynecological cases took the fifth place instead of the sixth. In 1906, the hospital was burned. When we resumed dispensary work again in 1907, gynecological cases took the fourth place, and the third place a year or two later. For the year beginning May 1, 1912, and closing April 30, 1913, they were second in numerical order.

Upon the average, nearly every fifth woman of both the new and return cases during the past year has been a gynecological patient.

* A paper read at the Annual Meeting of the Korean Medical Missionary Association.
More than half of our dispensary receipts are from this class, though our charges are very modest, 50 sen for the first examination, and 25 sen for each treatment thereafter.

Though our clinics are for women only, and only women physicians and helpers are employed, yet with the exception of the "Ge sang" (妓女) or dancing girls, or of concubines who were formerly "Ge sang," we find Korean women most shy about the necessary examinations and treatment. Even an old grandmother with prolapsus uteri or similar trouble wishes to wait until the very last patient is treated and gone, and will then want even the helpers to leave the room before she will tell me about her condition and will be yet more shy about showing it. Considering many other things one would scarcely expect such extreme modesty in Korean women, yet it seems innate and even more noticeable than in America.

As to variety in our gynecological cases in Korea, in going over the records of the past year I note amenorrhea, menorrhagia, metrorrhagia, dysmenorrhea, sub-involution, lacerations of the cervix and perineum, vaginitis, pruritus vulvae, cervicitis, the different displacements of the uterus, polypi, fibroids, carcinoma uteri, arrested development even to total absence of uterus and vagina (four cases this year), urethral caruncle, urethritis, cystitis, vesico-vaginal fistulae, rectal and anal diseases, ovarian tumors and pyosalpinx. Venereal ulcers I have not found common, nor acute cases of gonorrhea.

Prolapsus uteri is quite common—there were seventeen new cases of prolapsus in the third degree recorded during the past year—due not to the mode of dress of the Korean women, as is often the case with their corseted sisters, but to getting upon their feet and about their work too soon after parturition, while the uterine body is large and heavy and the supports still lengthened and lax. No doubt you have all met with some of the terrible consequences of the native treatment of prolapsus, which consists in the protruding organ being wrapped in cotton saturated with oil, and then literally burned off. I presume there must be some good results, but naturally it is the failures who come to consult us, cases where the sloughing following the burning has gone on until a vesico-vaginal fistula, or a recto-vaginal fistula, sometimes both, have resulted. One patient, brought to me in a Korean chair, who had recently gone through this treatment, had a large bloody tumor still protruding as big as two fists. At first I took it for the uterine body, but it was the bladder turned wrong side out through the very large fistula caused by the burning. It was possible to catheterize the ureters by sight! Another case, in which the injured parts were in
the sloughing process and already leaking urine, was brought to me in the later stages of lock-jaw. So I might continue, citing similar results with slight variations.

Upon the other hand, there are numerous cases where the result of the burning was certainly effectual in that more or less complete stricture of the vagina or cervix followed. But there are cases of younger women still menstruating who come to have the parts re-opened; others come in difficult labor because the cicatrices will not allow the uterus to dilate. This past year we had two patients from the country with rupture of the uterus, which had occurred before they reached us, evidently due to the non-dilatability of the os. There have been others who with a little cutting and more tearing have been safely delivered. Some of these women appear to have no opening, but after searching for a little while one can usually pass a small probe. In this connection I will mention a unique case. A pregnant woman, one month beyond term, living about seven miles away, came walking into our clinic one day with absolutely no opening through which the child could be delivered. The question arises, how had the patient become pregnant? Upon questioning her I learned that the burning had been performed by a Korean woman shortly after the patient had conceived. The result had been complete stenosis leaving the pregnancy undisturbed. Labor pains came on at the end of ten lunar months. The patient took Korean medicine and tried the various superstitious customs and observances to make the baby come away but to no end, except the death in utero of the child. I put the patient on the table and, placing a catheter in the bladder, carefully made a small incision in the stretched membranes where the vagina should have been, deepened it until I reached the pent-up fluid, and then stretched and tore the tissues with my two thumbs. It was easier than operations I have done for similar conditions where the patient was not pregnant. The head was down all right, labor pains immediately began again, and quite a normal labor followed; but the child was so macerated that some of the skull-bones dropped out into my hands as it was being born. There was absolutely no odor, thus proving the perfect sealing. The patient made a good recovery, and was able to go home after one week.

The best treatment of these conditions is in the main preventive. I try myself, and induce all I can influence, to spread the information that parturient women should not be upon their feet while they can feel any tumor above the brim of the pelvis, and to warn all with prolapse of the womb to avoid the native treatment. Patients tell me ignorance
is one of the causes of their troubles; they had not heard before that foreign doctors could help them in such matters.

I have operated successfully upon a few cases of atresia of the vagina, and upon a number of vesico-vaginal fistulae. In one, the desired union was obtained with but one operation, but generally several are required. In another case, not due to burning but to a prolonged labor, I operated six or seven times, extending over a period of two years, before obtaining complete success. She has since borne three children all right, and is one of my most grateful patients. In these operations I do not cut away or waste any tissue, but split the bladder tissue off the vaginal, sewing it up with catgut, and then putting silk sutures in the vaginal mucous membrane, much after the method that I perform a hare-lip operation.

For the prolapses that are now coming to me more and more frequently before the burning, my routine treatment is to apply argyrol or burnt alum to the dreadful ulcerations that are frequently present, and then reduce, using a little glycerine or olive oil if necessary. I use a favorite depletive composed largely of alum, borax, and olive oil, with a little caustic potash as the most active ingredient. I then massage thoroughly, place the patient in the knee-chest position, balloon the vagina, and leave her for ten or fifteen minutes while the depletive is acting with the parts in good position. Afterwards, I teach the patient certain exercises to take morning and night upon her hands and knees to strengthen the uterine supports and the muscles of the abdomen and back, and direct her to return once or twice a week for repeated treatments as long as is necessary. In a number of cases where the uterine body, congested larger than a man's fist, had been protruding for periods varying from seven to ten years, after the first treatment it has not again protruded, often to my own surprise. I do not use pessaries, and seldom tampons (though Korean cotton makes tampons almost as excellent for such work as sheep's wool), as I eschew all such supports upon the same principle that I would not advise that a corset should be worn to do the work that the muscles should do. I depend mainly upon the depletion which reduces the inflammation, size, and weight; the knee-chest posture; daily exercises, and leave good Dame Nature to do the rest.

Having kept fairly complete records the past year, I had hoped, before preparing this paper, to go over them all carefully and work out the more frequent diseases with their probable causes. Owing to the pressure of other work I have been able to go over the first one hundred cases only, but I think they represent the average run of
cases, and the results obtained are about the same, the records tallying with those obtained in earlier cases.

The records show that nearly 50% of the gynecological cases come complaining of sterility (before it was more than 50%, showing that other gynecological complaints are now in larger proportion) and most of the patients complain of dysmenorrhea, leucorrhoea, or some attendant symptom.

In Korea, as in other countries, "sterility," which is the opposite of "fertility," is either relative or absolute, but owing to the higher death-rate in infancy and early childhood and the prevalence of Confucian ideas concerning the necessity of male progeny, we are appealed to by a comparatively greater number of patients in Korea with relative sterility than at home. About 46% of the patients were absolutely sterile; i.e., under circumstance favorable to conception, it had never occurred. This rate is a little higher than in the former record showing that our cases of relative sterility are proportionately less.

As at home, at least one in every six of the cases of absolute sterility seems to be due to the sterility of the husband, who may have more than one wife and several concubines yet never have a child born to him. A few cases are due to the non-development, or to the under-development, of the sexual organs, a few to fibroids of the uterus, some to conical cervix with pin-hole os, and others to flexion causing cervicitis with the obstructing plug of mucus. In cases of relative sterility, there may be flexion with cervicitis or fibroids, or there may be sub-involution, laceration of the cervix with much ulceration, catarrh and vaginitis. In some cases, probably due to a gonorrhoeal infection from the husband, there has been cellulitis with deposits and adhesions so that the patient aborts if she does conceive. The probable causes of sterility, either relative or absolute, written in their numerical order are as follows: ulcerated os; severe lenceorrhoea; pin-hole os; cervicitis, often with a flexion; cellulitis (remember its probable cause); sub-involution (often accompanied by a retro-version or retro-flexion); stenosis or occlusion due to native treatment of prolapse; lack of development.

As to the treatment in absolute sterility, I dilate the cases of pin-hole os, and in cervicitis I use soda to clean out the plug of mucus, and apply argyrol, and if there are flexions try to reduce them. There seems little to be done for the old cases of cellulitis except to disseminate the knowledge of its cause with warnings to young men against contracting gonorrhoea. I have done little for the sterility due to under-development, but think something could be accomplished by the use of electricity in this condition.
UNUSUAL CASE OF SARCOMATOSIS. (J. Preston Maxwell.)
Malignant Disease (Round-celled Sarcoma).

In relative sterility my routine dispensary treatment is "depletion" for vaginitis, inflammations, or congested uterus; for displacements, massage with the depletive, posture, and exercises. Except in case of menorrhagia or metorrhagia our depletive largely does away with the use of the douche; it is more cleansing as well as astringent and antiseptic. Tonic and constitutional treatment when needed. Entire cessation of intercourse for a season is perhaps often more important than the treatment given during that time. In relative sterility preventive measures are also desirable. Teaching the proper care of infants and young children, as well as the care of mothers during pregnancy, will lessen this class of cases, and its necessity should be emphasized.

I cannot report exactly how many cases of sterility have been relieved, for, like the ten lepers, only one may return to offer thanks; but occasionally such a happy one does return to proudly show us her baby which she calls "ours," and quite often those who have come to the dispensary from a distance for treatment send me the happy news later by letter; or, I hear through new patients that they come because they know of some one who bore a son after taking our treatment. So I believe the success compares favorably with that in other branches of medicine and surgery. One objection, unless there are at least two doctors to each clinic, is the length of time taken by gynecological work. One can treat a half-dozen ordinary cases in the time required to take the history, examine, and treat one gynecological case. I hold that each hospital for women ought to have a staff strong enough to attend to matters which are of such vital interest to Koreans, and ought to be, if they are not, to all peoples.

A large field for the investigation of subjects bearing on human fertility is open to us in Korea that might result in world-wide benefit could we but devote the needed time to it.

MALIGNANT DISEASE (ROUND-CELLED SARCOMA) PRESENTING UNUSUAL FEATURES.

By J. Preston Maxwell, M.D., F.R.C.S., Yunchun, Fu.

The case narrated below is unusual by reason of the rapidity of its growth; its distribution, and the general involvement of the thyroid gland. It is by no means certain that the primary growth was not in this gland, although it was not noticed at first; and if so, it is rare for primary sarcoma of the thyroid to involve the whole gland as depicted in the photograph.
K., a healthy young man aged 19, with a good family history and a clean record, was perfectly well in the beginning of December, 1914.

On or about the 10th of the month, he noticed a swelling of the gum over the left upper canine tooth. Five or six days later this discharged a little pus, and has occasionally discharged since that date. It gave him little trouble. About the beginning of January, 1915, he noticed several small swellings over the crest of the left tibia about the middle. About the same time he noticed that his neck was increasing in size. On January 27th, he noticed that the right eye was swelling and becoming prominent.

He entered hospital on February 8, 1915, and his condition then was stated as follows:

The patient is a well-nourished young man looking ill but not anaemic. There is no rise of temperature, and the pulse is 70 and regular. Over the upper canine on the left side is a small ulcerated growth, causing the lip to be slightly raised. It is of medium firmness, not tender, and does not bleed easily. Under the X-rays there is no alteration in the bone of the upper jaw, and the antrum is clear. The whole thyroid gland is enlarged to three times its normal size, and is hard to the touch, there being no soft areas. There is no obstruction to breathing, and the growth is not tender.

The right eye is protruded, and the lids fail to completely close owing to the pressure of a post-orbital growth which is evidently very vascular, as steady pressure on the eyeball reduces the swelling considerably for a short time. The conjunctiva about the lower fornix is markedly swollen and oedematous. The eye itself is normal, there is no optic neuritis and vision is but little impaired.

Over the crest of the left tibia, about the centre of the bone, there are three small firm nodules, but under the X-rays the bone appears normal. The urine was normal. The patient had a few round-worm ova and trichocephalus ova in the faeces, and the blood report was as follows:—

- **R. B. C. 5,950,000**
- **Diff. leucocyte count:** Polymorphonuclear, 75%
- W. B. C. 8,000
- Hæmoglobin, 85%
- Parasites, none seen.
- Heart and lungs normal.

On February 13, 1915, a nodule, which grew rapidly, was noticed in the subcutaneous tissue on the left side of the scrotum. By this time the right eye had only perception of light remaining, and the cornea was becoming affected by the exposure. The left eye was on this day noticed to be a trifle prominent, and the lower fornix reddened
and a little oedematous. Vision was perfect and the fundus normal. By February 20, the eye was markedly protruded, and the vision almost gone. The right eye started haemorrhage from a spot on the bulbar conjunctiva which was stopped by adrenalin and a light bandage. His general condition was much worse, temperature 101°, pulse 120, man hardly able to stand. He died three days later without any further bleeding from the eye. A piece of the growth from the gum was removed and proved to be a round-celled sarcoma.

DIFFERENTIAL BLOOD COUNTS IN SYMPATHETIC OPHTHALMIS.

By E. J. Stuckey, B. Sc., M.B., B.S., Union Medical College, Peking.

One of the most difficult problems which confronts the ophthalmic surgeon is presented in a case of perforating injury of the eye. He has to decide whether the injured member should be removed, or whether a long-continued effort should be made to preserve it. Many of the factors in this problem are mutually antagonistic, and he has often to decide on a narrow margin between pro and con. And always in the background hovers the dread spectre of sympathetic ophthalmitis which sometimes in most unexpected and tragic fashion attacks the sound eye. This is the dominating factor in the situation. Anything which makes an early diagnosis of sympathetic ophthalmitis possible would give sure ground for action: either to persevere in the measures for saving the injured eye and a greater or less measure of vision therein, or else to sacrifice it in the interests of the sound eye.

A paper by Brownlie in *The Ophthalmoscope*, October 1915, gives a résumé of recent investigations of the leucocytic blood count in sympathetic ophthalmitis, and records the encouraging results obtained at Moorfields Hospital, London, by the use of "606" for the treatment of this condition.

Investigations by Brownlie showed that in almost every case of sympathetic ophthalmitis there was a typical blood-picture. There was a marked increase in the number of large mononuclear leucocytes and some increase in the lymphocytes, while the polymorphonuclear cells were diminished. The total white cell count did not vary much beyond the normal limits. He puts the average blood-count in sympathetic ophthalmitis as follows:—
He also points out the striking similarity between blood counts in certain protozoal diseases—malaria, syphilis, ankylostomiasis, trypanosomiasis, kala-azar—and sympathetic ophthalmitis. On the analogy of the blood condition in syphilis, Coats believes that this may indicate a protozoal infection as the cause of sympathetic ophthalmitis; an opinion which is encouraged by the success of treatment by "606."

A recent case in our clinic demonstrates the value of a leucocytic blood-count in the early diagnosis of sympathetic ophthalmitis, and also the rapid return of the blood count to normal after the injection of "606."

Mrs. R., aged 56, British, was sent to me on March 20th by her medical attendant. On March 5th she had been shaking the dust out of her fur boa, and the metal "nose" of the beast, which was fixed on by a nail, about 1 1/4 inches long, flew off. The nail penetrated the outer part of the right upper lid and entered the globe. The patient hastily put her hand to her eye and thinks she probably pushed the nail further in; her own attempts to remove the nail failed. She called her husband, who pulled the nail out; he says the nail was imbedded about half an inch and was pointing downwards and inwards almost tangential to the globe.

She was seen three-quarters of an hour later by her medical attendant, who reported: "Either at the time of the accident or during the efforts at extraction, the iris was wounded and bleeding took place into the anterior chamber; there was no prolapse of the iris. Nothing further could be made out at the time, so the usual antiseptic treatment combined with a fixation pad over the eye, dilatation with atropine and confinement in a dark room was ordered. The case progressed favourably and tension remained normal. Examination of the lens was postponed until March 14th, and then traumatic cataract was found to exist." I ascertained from the patient that atropine was only instilled once. On examination on March 20th, no scar in the right lid could be made out. At the upper part of the corneo-scleral margin, a trifle to the outer side of the mid-line, was a small patch of haziness with a leash of vessels converging on it from above. The pupil was moderately dilated, irregular in outline, and immobile. The lens was opaque; on the capsule in the outer part of the pupil was a fine black line—probably from previous adhesions of the iris. Tension
was normal and there was no tenderness on pressure. Atropine was instilled three times, but three hours later there was no dilatation.

The history as regards malaria or syphilis was negative.

Blood counts on three separate slides were made by Dr. Smyly and Dr. Young with the following results:

<table>
<thead>
<tr>
<th>Cell Type</th>
<th>First Count</th>
<th>Second Count</th>
<th>Third Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polymorphonuclears</td>
<td>34.8%</td>
<td>42.1%</td>
<td>33.8%</td>
</tr>
<tr>
<td>Lymphocytes</td>
<td>53.8%</td>
<td>41.7%</td>
<td>51.4%</td>
</tr>
<tr>
<td>Large mononuclears</td>
<td>10.9%</td>
<td>14.2%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Eosinophiles</td>
<td>0.5%</td>
<td>2.0%</td>
<td>0.</td>
</tr>
<tr>
<td>Mast cells</td>
<td>0</td>
<td>0</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

Patient returned home, and had atropine instilled twice a day.

I saw her again on March 29. The pupil was exactly as on the previous visit. The injection at the site of the wound in the limbus was almost gone. There was no pain or tenderness on pressure. The left eye had vision 6/5; the fundus was pink, and the optic disc was almost the same colour. So the margin of the disc did not stand out as sharply as it generally does. The field of vision was tested roughly and found to be normal. A specimen of blood was taken but owing to the pressure of College examinations was not reported upon for several days. The result was as follows:

<table>
<thead>
<tr>
<th>Cell Type</th>
<th>Count</th>
<th>Count</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polymorphonuclears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphocytes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large mononuclears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eosinophiles</td>
<td>1.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mast cells</td>
<td></td>
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</tbody>
</table>

On the strength of this report and the fact that the injured eye was sightless and inoperable, I wrote to the patient's medical attendant and advised enucleation.

On April 4, in the afternoon and evening she had pain in the injured eye, which was relieved by bathing in hot lotion. I saw her on the afternoon of the next day. The iris was cloudy, the cornea slightly hazy, and there was some pericorneal injection. At the time of examination the eye was not painful or tender.

On April 6, ether was administered and the right eye enucleated. The conjunctiva was drawn together but not sutured.

On April 12, the blood count was:

<table>
<thead>
<tr>
<th>Cell Type</th>
<th>Count</th>
<th>Count</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polymorphonuclears</td>
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</tr>
<tr>
<td>Large mononuclears</td>
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<td></td>
</tr>
<tr>
<td>Eosinophiles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basophiles</td>
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</table>

On account of this report the left pupil was dilated with atropine and the eye carefully examined. The fundus was normal except that
The China Medical Journal.

the margins of the optic disc were slightly blurred. There was no keratitis punctata, and no vitreous opacities were observed.

On April 15, the patient was given an intravenous injection of arsaminol 0.5 gm. in 0.4% saline solution. The next two days she had a rather severe reaction with nausea and vomiting.

On April 19, an examination of the fundus showed that the margins of the optic disc were well defined. The blood count on that date was:

| Polymorphonuclears | ... | ... | ... | ... | ... | 69.0 % |
| Lymphocytes | ... | ... | ... | ... | ... | 21.7 |
| Large mononuclears | ... | ... | ... | ... | ... | 7.5 |
| Transitionals | ... | ... | ... | ... | ... | 1.8 |
| Eosinophiles | ... | ... | ... | ... | ... | 0 |
| Basophiles | ... | ... | ... | ... | ... | 0 |

On April 28, the socket of the right eye was well healed. The fundus of the left eye appeared normal and the blood count was:

| Polymorphonuclears | ... | ... | ... | ... | ... | 67.4 % |
| Lymphocytes | ... | ... | ... | ... | ... | 26.0 |
| Large mononuclears | ... | ... | ... | ... | ... | 4.1 |
| Eosinophiles | ... | ... | ... | ... | ... | 0.8 |
| Basophiles | ... | ... | ... | ... | ... | 1.7 |

These five blood counts appear to give a clear picture of events in the two eyes. The first two counts indicated the presence of active mischief in the injured eye (and therefore danger to the other eye), despite the fact that clinically it appeared to be perfectly quiet; an indication confirmed by the lighting up of inflammation in that eye.

The third count seemed to indicate that a week after enucleation of the injured eye the sound eye was still in danger of sympathetic ophthalmitis. The fourth and fifth counts showed how speedily this danger was removed by the injection of arsaminol.

If similar clear indications could always be obtained in such cases, we should have a scientific control of both prognosis and treatment.

Ophthalmic Injuries of Warfare.—A. W. Ormond (Practitioner, May, 1916), groups the cases that have come under his care at the base hospital into those which have consisted in repairing lids, replacing skin that has been torn away, and rendering sockets capable of holding artificial eyes, those in which the vitreous is filled with blood in cases of concussion blindness, and those in which constitutional disease has become apparent owing to the strain and stress of trench life. With regard to foreign bodies in the eye, the writer has been struck by the almost entire absence of sympathetic ophthalmitis and he has seen nothing of the insidious variety of irido-cyclitis. This is quite contrary to expectation.
CHOLELITHIASIS: EXCLUSIVELY LEFT-SIDED PAIN.

C. A. Hedblom, M.D., and A. R. Kilgore, M.D., Harvard Medical School, Shanghai.

Gall-stone pain beginning on the right side and referred to the left side is, of course, a very common sequence, and by various writers is stated to be usually associated with adhesions to the stomach. Pain on both sides, more pronounced on the left than on the right, sometimes occurs. Left-sided pain from gall-stones in cases of transposition of the viscera may be expected and such cases have been reported. Exclusively left-sided pain from gall-stones in a normally situated gall-bladder is, however, very uncommon. In the literature at our disposal we have found only one series of cases reported (Records of Boston City Hospital) in which the pain was said to have been predominantly left-sided in a few instances, i.e., in 6 out of 226 cases.

The difficulties of diagnosis in cases of gall-stones with obscure signs seems to justify a brief mention of the following unusual case.

The patient was a white woman, aged 65 years, married.

Family History: Unimportant. Two children living and well.

Past History: Twenty years ago a small mass was removed from the left breast on suspicion of malignancy. She does not know the microscopical diagnosis. No history of typhoid fever.

Present Illness: For twenty years, ever since the operation on the left breast, she has had recurring attacks of pain under the left costal margin, usually beginning well out in the flank, sometimes extending up over the precordia and, during the past year and a half, occasionally down the left arm. The attacks have been very much more severe lately and have come at more frequent intervals; there were several during the course of the past year. She has always had some nausea with the severer attacks, and this has been worse lately and has gone on to vomiting. She has never vomited very large amounts at once, or stale food, and has never vomited blood.

She has noticed, especially lately, that the attacks tend to come on after considerable physical or nervous strain; climbing two flights of stairs sometimes brought on distress in the left side. Ten days ago

she had quite a severe attack lasting several days which she attributed to the excitement and work of changing her residence the week before. She was seen just after this attack, but nothing of note was made out on physical examination.

Last night, at twelve o'clock, she was wakened from sleep by another attack of severe pain, was nauseated, vomited several times and fainted once. Relieved by morphia till morning. When another severe attack came on and she was brought to the hospital.

She is about 5 lbs. under her normal weight. Bowels normal. No urinary symptoms except that three years ago she had a little burning for a short time. Never jaundiced.

Physical Examination: Thin, old lady, lying on her right side with knees drawn up. The findings of interest were:

Tongue, moderately coated.

Heart, normal in size, position, and sounds. No peripheral arteriosclerosis made out. Systolic blood-pressure, 125 mm. Hg.

Abdomen, level, slightly tender all over. (There was no tenderness when the abdomen was palpated an hour after the onset of the attack at midnight.) No spasm can be made out and no abnormal masses or viscera are palpable.

Temperature, 97.5° F., Pulse 70.

Examinations of urine and faeces showed nothing abnormal.

Note,—written the following day: She has continued to have pain, though not quite so severe, and to vomit occasionally bile-stained, but not bloody, material. Temperature and pulse have gone up to-night (Temp. 100.5° F.; Pulse, 100) and her blood shows a white count of 22,000. The pain has now shifted over as far as the center of the epigastrium and examination shows a little spasm of the right rectus in the upper quadrant, but no localized tenderness. A little distension was relieved by enema with effective gas and fecal results. In view of the temperature, pulse, white count, and spasm of the rectus muscle, operation was decided upon. This revealed one large stone filling the gall-bladder which was in its normal position. The gall-bladder wall was only a little thickened and there were no adhesions worth noting. A cholecystectomy was done.

During the first week of convalescence she had occasional pains on the left side, described as being similar to, but not so severe as, those of the attacks before operation. Six months have now elapsed since her discharge and she has had no severe pain since she left the hospital. She reports that she has felt better than she had for years before. At rare intervals she has a feeling of discomfort in the same
location as her original pain, and she has noticed that this is always associated with gas in her stomach and is relieved by belching. It has been suggested that this offers a possible explanation of the previous attacks, the left-sided pain being really stomach pain brought on by the reflex irritation of the gall-stone.

**COMMENT:** A woman, aged 65 years, presents a history of twenty years of recurring attacks of pain in the left flank, with radiation to epigastrium, precordia, and sometimes to left arm, but never with any pain or tenderness on the right side; attacks apparently brought on by over exertion.

Except for the duration of the history, the story suggests angina (i.e., of the abdominal type). The length of her history, the normal findings with respect to the heart and blood-pressure, the severity of the attacks with vomiting and negative urinary findings should have suggested gall-stones to us, but it was not until she developed, for the first time, fever, elevation of pulse, high white count, and spasm in the right upper quadrant, that the diagnosis was made.

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**A SURGEON IN SERBIA.**

**HONORARY COLONEL HOWARD G. BARRIE, M.D., F.R.C.S., Kuling.**

In the wars of recent years the terrain has come to occupy an important place in all considerations of military surgery and is quite as deserving of discussion as the various forms of missiles, their respective velocities, and the variety of wounds inflicted. Its bearing upon wounds observed in Serbia may be said to hold a midway position between the effects seen in the South African campaign and those which are so general in France to-day.

We had in South Africa a brilliant scintillating atmosphere which contained a minimum of moisture. The soil was light, porous, sun-disinfected, and, as a rule, free from contamination by men or animals, as areas were vast and population scarce. Vegetation was stunted and sparse, in many places being nothing more than a few hardy little shrubs. It could not be said that the flies were particularly numerous, consequently, the soil was comparatively free from decaying vegetable and animal matter or other infective material. Under such favourable conditions, if injuries were spattered with soil or fragments of rock due to the explosion of shells, they yet healed with surprising rapidity and the healing was accompanied by a minimum degree of suppuration. Probably in no other war were injuries that
might be legitimately considered grave treated with so little attention, and yet with so large a proportion of recoveries. It is not overstating the case to say that injuries could be daubed with soil with relative immunity upon many battle-fields for they were high and dry and free from artificial contamination.

Besides personal experience in the South African War I had some opportunity, prior to going to the Balkans, of observing the conditions prevailing in France. They were entirely different from those seen in South Africa. The frequent over-cast skies in France, and the often flat or low lie of the country-side, were conditions promoting a good deal of moisture, if not on the surface usually in the trenches. Population abounds, domestic animals are numerous, and vegetation is abundant. The presence, therefore, of decaying animal and vegetable matter and excrement is so very common that it is extremely difficult to prevent its entrance into wounds. Hence the intense degree of infection and suppuration so much in evidence in France to-day, which presents so great a contrast with what was seen in the South African War. A wounded man, more often than not, falls into mud or filthy water in the trenches of France, and his wounds from the outset become infected from this source even if they have the good fortune to escape infective material driven in by the missile. In South Africa it was considered good routine treatment of bullet-wounds of the abdomen to administer opium, ensure rest, and place the patient in the Fowler position. Encouraging results followed this line of treatment. Such a procedure is wholly devoid of encouragement in the battle-fields of France. The great base-hospitals of England and France are peculiarly free of patients with abdominal wounds, because they do not live long enough to reach these hospitals when subjected in a routine manner to expectant treatment. Terrain conditions such as they exist in France bear no small share of the responsibility for these results. Contamination of hands, skin, and clothing is so general that infection of wounds follows as an inevitable outcome.

In Serbia, terrain conditions occupy a place of importance midway between the two already described. Where they differ it is always with an approximation towards conditions existing in France. Speaking generally for Serbia, the altitude, the hilly configuration of the country, and the sparse population are factors making for cleanliness. About human habitations conditions are quite as unfavourable as in the worst areas in France, but such areas are limited. Human filth plays a tremendous part in fouling the soil. Water-closets are emptied by pumping into waggons, and the contents are often dumped about
promiscuously and not even buried. Surface drainage is largely practised, hence the tendency to soil pollution.

The Commissariat. For the administration of this important department the army possesses an admirable organization. It is administered upon principles of rigid economy and neither friends nor foes are plundered to provide daily supplies. Usually the Serbians eat but two meals daily. There are, of course, many exceptions, but the general statement stands. There is an infinite amount of coffee-drinking and cigarette-smoking, especially by the leisured classes. Two meals a day with such luxuries ad lib. tend to produce a physiological balance which is easily disturbed. Irritable hearts are common, and vitality is somewhat reduced. When exertion is greatly increased, or hardship encountered, or, if through the exigencies of war, one of the two meals is not forthcoming, the soldiers quickly exhibit symptoms of lowered resistance. A wounded man suffering from a relative degree of starvation is under a tremendous handicap as he begins his life-and-death struggle in the hospital. With few exceptions our patients were under this handicap. The authorities did their best to meet our demands that hospital food should be of such a quality and quantity that would justify a hope that, other things being equal, our patients would recover. But it was like squeezing juice from a stone and, knowing the circumstances, we found it impolitic at times to attempt to push home such requests, preferring to make good the deficiencies ourselves. But even in one hospital a foreign medical unit cannot go on indefinitely making good the deficiency of inadequate rations, so that with an occasional short period of improvement here and there, things went on the even tenor of their way, and poorly nourished patients continued to die. The conditions of life in Serbia during the present war are much below what they should be. Previous wars have exhausted not only ammunition, but also clothing, bedding, and food supplies, and on the whole the country is subsisting upon hard fare indeed. The authorities provide for the ordinary soldier the best food available and with admirable regularity, but at best it is still inadequate. Surely there is something profoundly moving in the spectacle of the grim determination and dogged courage of a proud people who, overshadowed by poverty, make no complaint—not even that their best friends can detect—but unite their remaining strength to resist the invaders of their sacked country!

Army Medical Organization. Considering the primitive facilities that are employed and that seem to spring out of the earth when wanted, the authorities accomplish nothing short of marvels in the
matter of transportation of wounded troops. Ordinarily, transportation is effected by ambulance trains and simple canvas-covered single horse waggons. The trains are made up of third-class carriages, and coaches provided with a system of iron shelves upon which stretchers bearing wounded men are placed. Neither of these kinds of conveyances are numerous. At times of stress levies are made freely: railways contribute goods-vans, and open trucks; the adjacent country is scoured for ox-waggons; the towns provide various traps, and its carriages are captured in a net of soldiers who take up their positions at the street corners where they intercept carriages and order every driver to report to headquarters instanter. And they are obeyed despite the grumbling of the fares who are unceremoniously turned out of their carriages. Until the mass of wounded are transported there is not an available conveyance for the ordinary business of the day in all the country-side. Refinements in the form of motor ambulances or even comfortable horse ambulances are not known and if they were there are no roads upon which they could travel.

Provision for rendering first-aid was passable, but for the nursing and feeding of patients while in transit there was little. We are familiar in Europe with detailed arrangements for the safety and comfort of the wounded from trench to base hospital. Just behind the trench is the first receiving station, often a dug-out, then comes the first dressing station, then the casualty clearing station, and finally the base hospital. An adequate body of doctors, nurses, dressers, and orderlies are found in their respective places and they labour tirelessly in a finely co-ordinated scheme to deprive death of its victims, and wounded men of needless suffering. In Serbia all such harmonized plans are conspicuously absent. Much in the way of planning for the wounded appears to be left to the inspiration of the moment. Doctors and attendants from outside countries do their best to solve problems as they arise at the base hospitals, but they cannot lift a finger to lessen the difficulties such as they exist in the advanced fighting lines. What nameless horrors would have been enacted had not other countries sent in Red Cross units, it is difficult to picture. The absence or scarcity of Serbian doctors, trained workers, hospital supplies, and common conveniences for the sick, the long delay experienced in getting patients to the base hospitals, and the great volume of wounded literally sprawling over and swamping the inconsiderable arrangements that did exist, produced upon the visitor a peculiar sense of heart-breaking and indescribable muddle. The effect upon wounds was naturally disastrous. Often hopeless suppuration and even secondary
hemorrhage were already established when our patients arrived at the hospitals. A pretty and touching sight was usually seen when long processions of wounded were proceeding slowly from the railway station to the hospital. Women, children, and old men lined the streets with their gifts of home-made wine, the hot sweet drinks which are so common in Serbia, and fresh fruit. These were freely offered to and ravenously devoured by the hungry and thirsty travellers. Turkish women were particularly liberal.

The absence of Serbian trained nurses is very noticeable. Duties such as our trained nurses perform are left to the tender mercies of the rough soldiery. Where we did discover Serbian women working in this capacity we looked upon them as curiosities. They were usually local women: excellent indeed in every way except in the all-essential—professional knowledge. There was all too little of this, but what there was made the nursing far and away superior to the perfunctory service of soldier orderlies. When the Serbs relied upon their own efforts they were driven to various improvisations, and while one admired their ingenuity, much service, rendered in the best of faith, was positively deadly in its results. It was often a case of fools rushing in, etc.; but such is human nature that some prefer to do something when to do nothing would be infinitely wiser. On the other hand, a Russian lady doctor did a tremendous amount of good by supervising a body of quite untrained workers and by so doing was able to keep a hospital of several hundred well in hand. In another case an Italian doctor, with the co-operation of a few ladies from the various consulates, made himself responsible for four hundred wounded men and did the work very creditably indeed. Second only to the value to Serbia of the qualified doctors from England, America, France, Greece, and Italy, I must mention the unique usefulness of the British and American trained nurses. No other country can boast of such women.

I have seldom been more stirred with thankfulness and admiration than in witnessing the splendid, courageous, and sustained display of skill and gentleness evinced by these nursing sisters in Serbia.

_The Nursing of an Army._—How these nurses have cheered and comforted the last hours of those who have made the great sacrifice, and sent home last words to wives and mothers, none may ever know; but in the womanly sympathy, the love, and the tenderness they have shown they have rendered their own gift, over and beyond their skilled and gentle ministrations that have restored so many to complete health, and saved faculties and limbs that otherwise would have been lost.—_N.-C. Daily News._
HEMORRHAGIC PURPURA CURED BY EMETINE HYDROCHLORIDE.

H. H. Morris, M.D., Shanghai.

Patient, a male Chinese, aged 29, married, was admitted to St. Luke's Hospital, Shanghai, October 27, 1915.

Chief complaint: bleeding from the gums.

Family history is absolutely negative as far as any history of bleeding is concerned.

Past History. Primary chancre four years ago, followed by pains in the bones and skin eruptions. Has had malaria three times. Gives no history of bleeding from slight cuts.

Patient left the hospital six days ago having been in for syphilitic treatment. For two weeks he had been receiving 7½ grains of Potass. Iodide three times a day, and had continued to take this, after going home, in the same dose.

Present Illness.—Three days ago, i.e., three days after leaving hospital, he began to bleed from his gums, and also developed a petechial eruption over the whole body. Had no other symptoms, except pain in his nose from ulceration and necrosis of the cartilage.

Physical Examination.—Nose is flattened out, and there is marked loss of the septum. Face, arms, trunk, and legs are thickly peppered with a petechial eruption consisting of spots varying in size from a pinhead to pea, and in color from a quite bright red to a dark purple. A few of the larger ones are raised, but the rest are not palpable, and do not disappear on pressure. These spots itch slightly but are not painful. Blood is oozing from his gums, and the receptacle at the side of his bed has a large amount of bloody saliva in it. There is one small sub-conjunctival hemorrhage in the left eye. There are several hemorrhagic blebs on his tongue and inner side of lips.

Examination of Faces and Urine.—Negative.

Examination of Blood: Leucocytes 2,400,
Erythrocytes 2,450,000,
Hemoglobin 55% (Tallquist scale).

Stained smear shows nothing abnormal in regard to leucocytes or red blood cells.

The day after admission the patient was put on Calcium Chloride, 5 grains, t. i. d. The next day this was increased to 15 grains t. i. d.

October 31st: Four days after admission bleeding is still going on and urine is full of red blood cells.

Blood test of faeces is positive.

November 1st: Patient was given ½ grain of Emetine hypodermically. This was repeated the next morning.

November 2nd: Bleeding from gums is slightly less, and urine is not such a bright red color. Given Emetine ½ grain this afternoon.

November 3rd: Emetine, grain ½, in morning. Bleeding has entirely stopped from the gums and kidneys. Petechiae are fading slightly. No more Emetine given.
The patient was discharged on November 12th, showing no signs of hemorrhage. He received 2 grains of Emetine all told.

This was apparently a true case of Hemorrhagic Purpura of unknown origin. The only possible cause might have been the administration of potassium iodide, but in other cases which have been reported as due to this drug the dose has been anywhere from one to three drams at a time, and the Purpura started up much sooner. This man received only 7½ grains three times a day, and the hemorrhage did not start until two weeks after he had begun treatment. Calcium in 15 grain doses was tried, as it has been of use in some of the reported cases, though not in all. The effect of the Emetine was almost magical. I think it may not have been necessary to give the fourth dose. Possibly three, or even two doses, would have been sufficient. Emetine was tried because of its known effect on the coagulation of the blood, though in Hemorrhagic Purpura, as a rule, the coagulation time of the blood is not retarded. In the present case this was not examined owing to lack of the necessary instrument.

SUBCUTANEOUS URETHRAL RUPTURE.

PAUL W. VAN METRE, M.D., Nakon Sritamarat, Siam.

The following case may be of interest because of the incidents connected with the accident, the difficulties attending the operation, and the perfect recovery which followed.

The patient was a Chinese named Liea Chaa, aged thirty-eight years, by occupation a general merchant. Father, brothers, one wife, three children, alive and well. Mother dead, cause unknown. Consistent opium smoker, amount not noted. Formerly drank wine daily, none last four years. Past medical history unimportant, except that at the age of thirty had a left-sided orchitis accompanied with dysuria and pyuria. Admits bare possibility of this being gonorrhoeal, but denies lues and all its symptoms.

Present Illness.—About fifty-six hours before reaching the hospital he was standing in front of his house intending to walk down to his boat lying in the river. A rotten board at the landing broke; he caught at something and was saved from being precipitated into the river, but his feet slipped from under him and he fell astride of an upright post. Was able to rise and walk to the house, a distance of about thirty feet, but with difficulty because of great pain in the perineum. Fearing he could not pass urine, he shortly attempted to do so at stool, but could pass none. After drinking some wine he felt relieved, but feeling some fluid passing from penis, looked and found it pure blood. Pain continued severe and being unable to pass any urine, he sent for the local government doctor who tried to pass a rubber catheter. No urine coming out, someone sucked on the end of the catheter, but still none came. His distress increasing, it was finally decided to bring him to the hospital, a day's journey by boat. Arrived at hospital late at night.

Examination.—The patient was apparently in extremis, pulse small and thready, respirations irregular but audible. (They were, in fact, little more than grunts.) Almost comatose, perhaps from much opium. On baring the abdomen, found a hard, rounded tumor, extending from pubes to above the umbilicus. Perineum swollen, puffy, and of a greenish-black colour which extended upward to the abdomen.
Treatment.—On account of unsatisfactory condition, only thing advisable seemed to be to empty the bladder. Therefore shaved lower abdomen, painted it with tincture of iodin, and thrust a carefully sterilized, long trocar directly into the mid-point of the prominence. Withdrawing the obturator, a stream of urine spurted some feet in the air. (On account of haste, the amount evacuated was not measured. Two attendants say it was more than a basin full, the capacity of which is 5,000 cc.) The patient at once breathed better, and was put to bed with a hypodermatic injection of morphine and atropine, given because he was an opium habitué. Slept well. No leakage from stab wound, closed with sterile gauze and collodion. There was no passage of urine per urethra, and, the bladder rapidly filling up, he was prepared for perineal section the following morning. Cutting down upon the urethra, came upon a mass of clots, much bruised tissue, and a completely severed urethra. After cleaning out the clots, experienced much trouble in stopping a very profuse bleeding, which in spite of best efforts continued to be alarming for several minutes. There was no hesitancy about clamping the cavernous body. Then had some trouble in locating the severed and retracted ends of the urethra and in getting a metal catheter into the bladder through the perineal opening. An ordinary retention catheter was inserted, also through the perineum, then the distal end was threaded back through the penile urethra and out at the meatus. The work of closing was but an attempt at a plastic operation, for the tissues were already severely macerated by the injury and the additional manipulation made the hope of primary union seem remote. The urethra was united with chronic gut, then the section, layer by layer, leaving in only a rubber drainage tube of No. 17 French catheter size. Retention catheter was fastened into the penis with adhesive plaster strips, and connected by long rubber tube with a drainage bottle after the patient was returned to bed. Potassium acetate was given in massive doses and the patient made to drink much water. Hexamethylenamine was also freely given in an attempt to secure urinary antisepsis. Except for a severe chill on the second day, followed by several lesser ones soon after, and the trouble experienced in getting the patient away from his opium, the recovery up to the fourteenth day was uneventful. On that day it was definitely planned to take out the retention catheter, which had been used daily to irrigate the bladder with boracic acid solution. During the early morning hours, however, the catheter slipped out of itself. The patient considered this most undesirable and tried vigorously to reinsert it, without telling an attendant. He forced the catheter out through the perineal wound, which had nearly closed. Our own efforts were unsuccessful with an ordinary cylindrical catheter, and we decided to wait and see if urine would come out per via naturalis. A certain amount did, and about the same amount drained through the perineum. The following day, an ordinary catheter was passed and from that time on the bladder was irrigated with weak permanganate solution. It should be noted that very free drainage of pus occurred around the sides of the retention catheter for several days after operation. The perineal wound healed steadily being stimulated with silver nitrate. An attempt to close the wound mechanically by gauze saturated with compound tincture of benzoin seemed to be of use. At any rate, the perineal leakage grew steadily less and the urethral flow increased, until leakage ceased entirely on the twentieth day. The patient appeared to be practically normal and was allowed to go home on the 26th day after entrance.

Conclusions.—Nature’s ability to heal a severe lesion, even in the face of what one would consider unsurmountable obstacles, measured by this case seems to be most remarkable. We do not attempt to say what amount of urethral mucous membrane was required to heal over the bridge, i.e., the catheter, but reiterate that the attempt at a plastic operation was but an attempt.
Native-made Heating Apparatus for Sterilizers.

AN INEXPENSIVE, NATIVE-MADE HEATING APPARATUS FOR STERILIZERS.

By O. T. LOGAN, M.D., Changteh, Huan.

The junk room of every mission hospital is apt to contain worn-out oil stoves of various patterns. We have been using for about six years the Khotal Blue Flame Oil Stoves that come with the Bramhall Deane sterilizers. They are very powerful but the parts subject to heat will burn out and it is both inconvenient and expensive to get new parts from home. We are fortunate in having connected with our hospital a Chinese who is a natural mechanic and inventor, and to him we are indebted for the adaptation of the native bellows and stove described below. The measurements of our bellows are given, but a larger or smaller one would probably do equally well. Before we bought ours we borrowed one for trial.

With the exception of the iron pipe, the whole apparatus is native-made. The bellows (wind box, 風箱) are made of wood and the stove of bricks with clay mortar. If charcoal is burned it is not necessary to make any opening for the removal of ashes, as the bellows blow the ash out as fast is it is produced. Here we have two kinds of charcoal called ʻpeh-tan ʻ(白炭) and ʻheh t'an ʻ(黑炭). The latter makes some smoke but it works better.
The reader has already found the weakness of the method—it is somewhat untidy. The room where the sterilizing is done should not be used for storing the dressings, etc., and if the room has a wooden floor, some protection would have to be devised. The objections, in our opinion, are more than counterbalanced by the advantages which are:

1. **Cheapness in first cost.** Our outfit cost less than $2.00.
2. **Ease of repair.** No expert needed, no parts to be procured from abroad.
3. **Cheapness of fuel and repair cost.** We estimate that the saving in fuel will be about $50.00 and in extra stove parts about $25.00 per year.
4. **Time saved in sterilizing.** The native apparatus does the work in about half the time that it took with the largest Kholtal stove.
5. **Peace of mind.** One is not haunted by the ever-threatened calamity of an absolutely essential piece of apparatus becoming inoperative through failure of the heater.

We have not experimented with different fuels but I believe that good coal would do the work if tolerably free from smoke and clinkers. The splendid coal that is mined in the north of China would probably work well.

Our sterilizer is, as the drawing shows, one of the sort with the generator separate from the body of the apparatus. We have given it hard use for more than six years and the cost of repairs, excluding that of burned out oil-stove parts, has been less than a dollar. Now that we have—as it appears—solved the heating problem, we feel that the sterilizing millenium has almost arrived.

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**CUSTOMS MEDICAL REPORT: HEALTH OF WENCHOW, CHEKIANG.**

By E. T. A. Steedford, M.B., B.Ch.

*June-September, 1914.* During this period the health among the foreign residents has been good. There has been one case of amoebic dysentery (June) and one case of typhoid fever complicated with cholecystitis (August). Death rate *nil.*

Among the native population syphilis and tuberculosis are extremely common. Syphilitic patients practically always come to hospital in the tertiary stage. Tuberculosis of bones and joints is very prevalent and
the Chinese are learning the value of operation in these cases, sometimes presenting themselves with the request to have the diseased bone removed.

Trachoma attacks a large proportion of the population and is responsible for most of the cases of blindness. It is rarely possible to get Chinese to submit to treatment long enough to effect a cure.

Leprosy does not seem to be very common. I have only seen the anaesthetic variety here.

During the short time I have been here I have been struck with the great frequency among tumours of the innocent variety—mainly fibroids.

Cholera, which often visits the city in the latter part of the summer, has not appeared yet. There have been no epidemics.

October, 1914-March, 1915. The health of the foreign community has been excellent.

A very large part of the work among Chinese has been surgical. Tumours, tuberculosis of bones, joints, and glands, eye operations, especially for entropion, fistula, sinuses, and piles account for the greater percentage of these cases.

There is a form of ascites prevalent here in men, and more rarely in women, from the country districts, which is not accompanied by enlargement of the liver or spleen. The liver is sometimes reduced in size but not always. In about one-third of the cases a history of diarrhoea occurring near the beginning of the trouble can be obtained. Schistosomum ova have only been found in the faeces of a few cases. The disease may be fatal in a few months, or may last over a year. I have not observed a case that lasted more than eighteen months.

Two cases of ankylostomiasis were seen. There was one case of anaesthetic leprosy, a boy aged nineteen years. According to the evidence of a neighbour, the boy's father, who died when the boy was three years old, had paralysed and anaesthetic hands and an ulcer on the sole of the foot. The boy had anaesthetic patches involving the 4th and 5th fingers and the neighbouring area of the palm of each hand, and a patch on the left buttock. There was commencing main-en-griffe of the left hand and paralysis of the left orbicular muscle. The ulnar, external peroueal, and great auricular nerves were thickened. The knee-jerks were exaggerated and the jaw-jerk was present.

The following is a peculiar case, the only one of its kind seen, in which no diagnosis was made. Boy, aged 18. On the right leg there was a line of ulcers extending from the base of the second toe across the
dorsum of the foot to the front of the internal malleolus, thence up the leg to the middle of the thigh exactly along the course of the internal saphenous vein. The ulcers had raised bases and varied in size from a few millimeters to 1 ½ centimeters in diameter; in some places they were almost contiguous, in others they were separated by an interval of 2 or 3 centimeters. Above the middle of the thigh, on a continuation of the same line, there were two small reddish nodules apparently about to break down. The patient said the trouble had begun five months before with small, hard, painful nodules at the base of the second toe; in about a fortnight these nodules had ulcerated. Similar swellings breaking down into ulcers had arisen progressively up the leg. There was no anaesthesia or paralysis. Treatment with mercury and arsenic and with local applications of caustics, had no curative effect. The patient did not stay long enough for potassium iodide to be tried.

Rheumatic fever is a curiosity here; one case, the only one during the year, was treated.

Towards the end of March epidemics of measles and smallpox broke out. As the Chinese do not bring these cases to the hospital, I have no first-hand acquaintance with these epidemics except in the case of a mission boarding school which was invaded by measles, and there all the cases ran the common course and no complications followed. From hearsay the smallpox epidemic does not appear to have been severe.

April-September, 1915. There has been a fair amount of sickness among the small foreign community here during these months.

A case of diphtheria occurred in April which quickly cleared up under antitoxin treatment. Round-worms and abscess of the arm in a child of sixteen months caused great constitutional disturbance and wasting.

A case of acute otitis media subsided without suppuration.

In September there was a case of fever, of which the cause is not clear, with two relapses, and apyrexial intervals of eleven and twelve days. When I was called to see the patient, a middle-aged man, he was suffering from fever and severe abdominal pain. He thought the fever had been present also on the two preceding evenings. The pain soon subsided, but the fever lasted for two days more, rising to over 103° F. at night and coming down to 99.5° or 100° in the morning. During the fever the pulse was rapid (110-130) but regular; after the disappearance of the fever the patient became collapsed, the pulse remaining rapid (110-120) and becoming bigeminal. It slowed down and became
regular in two days and patient improved greatly. The next attack of fever occurred eleven days after its first disappearance. The previous day the patient had walked about \( \frac{1}{2} \) mile and exerted himself more than since getting up. This attack lasted three days and was accompanied by irregular pulse. The fever and irregularity disappeared together. The second relapse took place in another twelve days. It was less severe and unaccompanied by any irregularity of the heart. It lasted three days.

During the summer the patient had been working out of doors a good deal surveying canals, but had not been exposed to the heat for several days preceding the illness, and the second relapse took place after the patient had been in bed for a few days with synovitis of the knee. The blood was examined during the first attack and during the second relapse, but no spirochaetes were found.

Cases of neurasthenia and influenza also occurred among foreigners. The hospital of 100 beds has been full, and at times over full, during this summer.

There have been no widespread epidemics. Cases of cholera occurred here and there during July and August. In July there were several cases of bacillary dysentery.

A case of hydrophobia was seen in April, following seven weeks after a dog bite.

An unusual case worth recording was one of acute bulbar paralysis in a man aged thirty-four years. He awoke one night and found that he could not speak clearly or swallow. When I saw him five days later he was suffering from complete inability to swallow, paralysis of both sides of the soft palate, of the right side of the face and of the right side of the tongue. Both vocal cords were freely movable. Temperature 102° F. Pulse 108. He was fed with the stomach-tube and given small doses of strychnine. About a month after the onset the facial paralysis began to show signs of improvement, and a fortnight later he was able to swallow a little fluid. Four or five days later the stomach tube was no longer necessary. About two months after the onset the palate began to move on phonation and a week later he was able to speak with hardly any nasal sound. Although the quick recovery suggests hysteria, the evident great distress of the patient when first seen, the high temperature, and quick pulse which continued for three days and for which there was nothing else to account, point against its being of that nature. No personal history of syphilis could be elicited, but his wife had had one miscarriage and no children during their three years of married life.
The China Medical Journal.

Vol. XXX. September, 1916. No. 5.

All communications on Editorial Matters, Articles, Letters, Exchanges, and Books for Review should be addressed to the Editor of the Journal.

Changes of address, departures and arrivals of members of the Association should be notified to the Business Manager, Dr. R. C. Beebe, 5 Quinlan Gardens, Shanghai. Members are requested to invite all missionary physicians who come to China and other parts of the East to join the Association.

Every member of the China Medical Association who has paid his dues for the current year, is entitled to a copy of the CHINA MEDICAL JOURNAL for the year, postage free. To those not members, the subscription to the JOURNAL is $1 Mex., per annum. In remitting by cheque please specify "Shanghai currency."

Editorial.

CO-OPERATION WITH THE CHINA MEDICAL BOARD.

Various questions which have arisen recently in connection with medical education in China will doubtless be discussed at our next Conference, and it may be well to give them some consideration beforehand. One important matter which requires further elucidation is the relation of the medical work of the missionary societies to the plans and policy of the China Medical Board of the Rockefeller Foundation. A year or more has now passed since the Rockefeller Foundation, through the report of its Commissioners, announced its intention to take a prominent part in the medical education of the Chinese. Preparatory and constructive work has been done, but, as is common in human affairs, not every expectation has been realized. Perhaps we are too impatient. It should certainly be remembered that Dr. Flexner, of the China Medical Board, cautioned missionaries in a public speech not to expect immediate results as the work the Board was undertaking was a slow one. "It will take time," he said, "to create a plant such as we want, and even more time to create the Faculty and to get the proper body of students. The more you co-operate, the more you help us with your support, not financial so much as moral, the sooner will our great object be realized."

It may be, also, that some of the expectations formed rested on misunderstanding. In every important argument and enterprise it is well to define the most significant of the terms used. Hence we should know what is meant by co-operation in this
connection. It does not necessarily mean the "pooling" of all resources, nor the active participation in the management of institutions of all the co-operators or their representatives; but rather certain mutual efforts towards the attainment of common ends, in which each side helps the other, yet is free to carry out its own particular work in its own way. Admittedly, one common end is the establishment in China of a system of medical education on a level with the best that exists in Western countries. Of course missionaries go further and desire to bring the students and practitioners of medicine in China under the influence of the Christian spirit. The China Medical Board has avowed its sympathy with this object but does not itself propose to do any missionary propagandism. As the lines of work nowhere cross, but run parallel most of the way—it may almost be said the whole of the way—mutual service and confidence should not be difficult.

On the one hand, missionaries can do much to lighten the splendid but heavy task which the Board has undertaken. On the other, the Board is in a position to help in a variety of ways the work of medical missionaries and others who are engaged in the dissemination of the principles and practice of Western medicine in China. The practical co-operation which is possible and desirable can be illustrated by the events which have already occurred and by the known plans for the future.

In Peking, where one of the Schools of the Board is to be established, the change in the medium of instruction from the Chinese language to English, necessitated sending fifty or more students to the Tsinanfu Medical School, and to enable the latter to meet the additional obligations it had assumed, it was given the sum of $150,000 gold. Financial assistance for a different reason has also been given to the Hunan-Yale Medical School in Changsha. No permanent conditions were attached to these monetary grants. In neither instance has there been, nor will there be, the slightest interference with the management of the institution aided, for we understand that the Board holds strongly that institutions are best managed when the control is undivided.

Plans for the Shanghai School have not yet been formulated. In the Peking School, missionary societies co-operate by being fully represented on the Board of Trustees which determines the
general policy of the institution. As to staff appointments, the equipment, and the management of the School, the China Medical Board, through its majority on the Board of Trustees, will have full control, consistently with its course in dealing with the Changsha and Tsinanfu institutions.

Then in hospital work there can be co-operation. The China Medical Board will have hospitals of its own in direct connection with its medical schools. But it also plans to send graduates to other hospitals in various parts of the country to act as internes, study local diseases and medical problems, and in other ways acquire further medical knowledge and experience. On the recommendation of the Resident Director, the Board will be prepared to give assistance, if it is desired, to a limited number of conveniently located hospitals which can offer the necessary facilities for this training. The salaries and allowances of any members of the hospital staff supported by the China Medical Board will be paid through the missionary societies.

Further, as part of its general scheme, the Board desires to see medical work strengthened almost everywhere in China and therefore may eventually give help to hospitals on a wider scale. It is not the intent, however, to overshadow the medical work of the missions, and the effort will be made to avoid anything that may tend to slacken independent missionary enterprise. It is likely that assistance will be mainly given to those institutions that already possess certain elements of strength in the way of staff, buildings, and equipment, or those which the mission concerned is itself prepared to support more substantially in the future. Consequently, poorly equipped hospitals in out-of-the-way places are not likely to receive as much assistance, if any, as the stronger hospitals in important centres, particularly those near medical schools, which only need development to enable them to cooperate efficiently in the general scheme of medical education and research. The assistance given may be in the form of monetary grants towards building funds, or for the purchase of equipment, or through the support of Chinese or foreign additions to the staff. Over such hospitals the Board will exercise no control. The physicians who reinforce the staff of a missionary hospital will be regarded as missionary physicians, except that they cannot be
moved from the hospital to which they were sent without consultation with the Board and its approval.

Later, when the medical schools are organized and equipped on a proper basis, it is hoped that arrangements can be made for doctors supported by the China Medical Board to spend certain periods at regular intervals in graduate study at the schools, in order that they may be kept in touch with advances in medical science, but otherwise there are no restrictions. Hospitals which receive monetary grants are not even bound to accept internes. Whatever is given is given outright. To use a colloquial phrase, "there are no strings attached" to the gifts. The only influence which the Board can exert over aided institutions lies in their hope of future benefits. For instance, financial aid will usually be stretched over a fixed period, probably five years. It will depend on the judgment of the Board as to the needs of the situation and the wisdom with which previous grants have been used, whether at the end of the period the hospital will continue to receive assistance. For the present the Board must depend for its information on this point mainly on the reports of the Resident Director, but several other members of the Board have also seen a great deal of medical work in China and will therefore be able to pass on matters of this kind more intelligently and more sympathetically than they could otherwise be expected to do.

Secondly, in connection with the medical schools of the China Medical Board there can undoubtedly be missionary cooperation although such schools, in all that appertains to the medical education of the students, will be entirely under the control of the Board. In addition to the influence which missionary representatives on the Board of Trustees of such an institution as that at Peking can exert, the missionary societies can help forward their own work and at the same time aid the Board by suggesting for appointment as teachers on the staffs of the schools physicians whose professional qualifications are acceptable to the Board, and by sending at least some of their best and brightest Christian students to those schools so that strong Christian influences may always be present in them.

Thirdly, in the pre-medical education of students there can be cooperation. At first, the Board may find it necessary to
open preparatory departments in its schools for the training of its students, but this need not prevent missionary institutions from undertaking the same kind of work. In fact, the Director of the Board has already been authorized to negotiate with certain mission institutions which teach in English with a view to strengthening their scientific departments, particularly those of Chemistry, Physics, and Biology. The aid may take the form of monetary grants to defray the salaries of one or more professors in these departments. An institution receiving such aid is perfectly free to send its students elsewhere for their medical education than to the schools of the Board if it so desires.

Lastly, we can be confident that in the schools and hospitals of the Board, religious organizations will be given every reasonable facility to do religious work. There may be branches of the Y. M. C. A. established in connection with the schools, but if a missionary society wishes to have a hostel of its own near the school for the religious care of the students it sends there, we have been assured that the Board would welcome such an enterprise.

Of course, difficulties may arise at any time in co-operative schemes of this kind, but they should not be insuperable, and to attain the great end of missionary enterprise, sacrifices on our part, if need be, are worth making. The China Medical Board has the resources and the purpose to establish and maintain its schools in the highest state of medical efficiency. At the same time it offers to strengthen, according to its own judgment, the medical work of missionary societies, and it opens freely the doors of its institutions to missionary effort. Great opportunities lie before us, and it rests with us to avail ourselves of them.

CONSTITUTION AND BY-LAWS.

At the last Biennial Conference an Executive Secretary was appointed, two Councils were created and other important business transacted which necessitated changes in the Constitution. As there was no time to revise this before the Conference closed, the Association empowered the Executive Committee to make the necessary changes. On taking up the work, however, the Committee found that for various reasons it was advisable to
recommend the revision of the whole of the Constitution and By-laws. Consequently, with this number of the Journal, there is issued a draft of the Constitution and By-laws as altered by the Executive Committee, which is submitted to members of the Association for their present consideration and for whatever action is deemed necessary at the next Conference. It might be well for those who desire to make further changes to communicate with the Executive Committee so that the amendments proposed may appear beforehand in the Journal.

THE NEXT BIENNAI MEETING.

It is expected that the next meeting of the China Medical Missionary Association, which is to be held in Canton, will be of special interest and value to all those who can attend. The doctors of that section have already organized for carrying out the local details for the meeting, and the work of the conference.

The National Medical Association at its last meeting in Shanghai this past winter, decided to hold its next meeting in Canton at the same time as the China Medical Missionary Association so that we could hold joint meetings for discussion of professional subjects.

This is the first meeting of our Association to be held in the South and it is hoped that there will be a large attendance. It is expected that the meetings will occur soon after the Chinese New Year which comes during the last week of January.

In order that we may make arrangements for transportation and get special rates it is necessary to know how many propose to attend. Will those planning to go from North and Central China let me know at as early a date as possible?

ROBERT C. BEEBE.
The China Medical Journal.

Medical Reports.

The Moukden Medical College Report for 1915
Sixth Annual Statement.


Lecturers:—Ethel Starmer, M.B., Ch.B.; A. Russell Young, L.R.C.S., L.R.C.P. (Ed.); P. D. Pedersen, M.B., Ch.B. (Ed.).

Number of Students, 106.

Total Expenditure for the Year, £2,434. 10. 2.

"Once more the Moukden Medical College sends forth its Report in the midst of War. Last year at this time one of our Staff was at the Front, and this new year finds us with three of our number tending the wounded. In other ways also the War is affecting us, but we are thankful to God that in spite of all difficulties we are able to carry on with much encouragement the important work which is laid upon us.

"During 1915 an important forward step was taken in the completion and occupation of the new Dormitory Block or Hostel. It had been hoped to open it early in the year, but the delay caused by the War prevented this, and the students continued to live in the College building until the end of the summer session. When they returned after the long vacation, however, their new domicile was ready for them, roomy, airy, and bright. This change implied material alteration in the daily life of the students, but the alteration is in all points an improvement."

"The teaching work throughout the year has been carried out as planned, difficulties notwithstanding: but the Staff aims at a much higher degree of effectiveness than has been attained hitherto. It is a new experience for Chinese young men to find examinations conducted with unrelenting rigour, and as we keep our standard high some fail to reach it, and must either give up study or consent to go down to a lower class. This causes the number in each class inevitably to dwindle as the years go on."
Interesting details are given of the medical work of the various classes, and of the Christian influences which surround the students and lead them into Christian activities. "It is the Christian physician we would see grow up in our College, and I do not think we shall be disappointed." It was a matter of great thankfulness to the Staff and the Board of Management that, in the month of May, fourteen of the students were admitted to the Church by baptism, some of the best men being among the number. Only a few now remain outside the Church, and these too manifest an interest in religion.

An appeal is made not only for medical men, but also for others of varied powers, to lead the students in evangelistic effort; to undertake the clerical and financial work; to supervise the physical training of the students; and a teacher of English. "Personal intercourse and personal influence are of vital importance if our students are to go forth as Christian missionaries and Christian physicians."

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**Union Medical College, Hankow, China. Annual Report for the Year 1915.**

**Staff:**—T. Gillison, M.B., C.M.; P. L. McAll, B.A., M.B., Ch.B.; W. B. Heyward, M.D., Ch.B., (on furlough); Eu Teh Fu (U.M.C. Graduate); Wang Kuo Chi'ang (U.M.C. Graduate); Chao Chi Sheng, B.A. (Chinese).

Number of students, 30.

Total Expenditure for the Year, Mex. $4,496.65.

The work of the College was carried on without interruption during the year. Changes in the staff have occurred, Dr. Heyward returning to England on furlough and Dr. Eu returning to his own mission. There is every prospect of a Chinese graduate of Edinburgh University joining the staff on a two years' engagement. Arrangements are being discussed for putting the College upon a more satisfactory basis both as regards staff, premises, and finance.

While welcoming the work of the Rockefeller Foundation in China, the writers of the Report are of the opinion that it will "not meet the need that our Union College is seeking to-day to meet. The standards for entrance will be so high that for years to come the numbers admitted will be very limited and the fact that the teaching is to be in English is another reason why we should push forward. The teaching of medicine and allied sciences must eventually be through the medium of the Chinese language and our own experience and that of other medical colleges is that the Chinese language is capable of in-
corporating the latest advances of science and of giving them adequate expression.''

Further, "we desire to see the medical profession of China uplifted, not only through a truer scientific knowledge of disease, its prevention, and its treatment, but by the infusing of those higher Christian ideals of responsibility and sacrifice which have made it such an honour and blessing in our home lands."

An earnest appeal is made for financial help, and for microscopes, pathological specimens and anatomical models and casts. Testimonies are given of the successful work done by graduates of the School.

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Soochow Hospital Report, 1914-1915.


Statistics for Year October 1st, 1914, to September 30th, 1915.

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<tr>
<th>In-patients.—Medical</th>
<th>Male</th>
<th>Female</th>
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<tr>
<td>Surgical</td>
<td>387</td>
<td>45</td>
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<td>Eye</td>
<td>187</td>
<td>13</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>20</td>
<td>85</td>
</tr>
<tr>
<td>Out-patients.—1st Class</td>
<td>2,900</td>
<td>699</td>
<td>3,599</td>
</tr>
<tr>
<td>Return</td>
<td></td>
<td></td>
<td>750</td>
</tr>
<tr>
<td>2nd Class</td>
<td>3,575</td>
<td>764</td>
<td>4,339</td>
</tr>
<tr>
<td>Return</td>
<td></td>
<td></td>
<td>626</td>
</tr>
<tr>
<td>Calls on Chinese</td>
<td></td>
<td></td>
<td>375</td>
</tr>
<tr>
<td>&quot; &quot; Foreigners</td>
<td></td>
<td></td>
<td>295</td>
</tr>
<tr>
<td>Strays, students, etc.</td>
<td></td>
<td></td>
<td>726</td>
</tr>
<tr>
<td>Total</td>
<td>12,364</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

General Operations, Major | 451
" " Minor | 510
" " on out-patients | 650

Total | 1,611

Total Expenditure for the Year, Mex. $26,206.13.
The hospital is now absolutely dependent on the Chinese for every expense except the salaries of the Americans connected with the hospital. Formerly it had a few endowed beds that brought in $25.00 gold, equal to $50.00 or $60.00 local currency, but they have all been dropped one by one and this year amount to none. "We are sorry to have our friends in America thus lose interest in our work, but the more we depend on the Chinese the more we get from them, until now we run an annual budget of twenty thousand dollars and still have enough for repairs and constant additions to buildings and equipment, and after doing all that have turned $4,000.00 over to the building fund for the new hospital and now carry a balance of over $4,000.00 to next year's account."

The actual cash now on hand for the new hospital amounts to $8,563.00 and enough has been promised to bring it up to $10,000.00. This, however, is only one tenth of what is wanted, but with money coming in every week the time is bound to come when there will be enough on hand to begin building.

Report of Church Missionary Society Hospital, Ningpo, Chekiang, 1915.

Staff:—A. F. Cole, M.R.C.S., L.R.C.P., (temporarily serving with His Majesty's Forces); Rev. H. Barton (Acting Superintendent); E. G. Sugg, Esq., M.D., (Temporary Physician).


Nursing Superintendent, Miss F. Furness.

Statistics:—

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major operations</td>
<td>459</td>
</tr>
<tr>
<td>Minor operations</td>
<td>321</td>
</tr>
<tr>
<td>Teeth extractions</td>
<td>400</td>
</tr>
<tr>
<td>In-patients: Men</td>
<td>514</td>
</tr>
<tr>
<td>In-patients: Women</td>
<td>300</td>
</tr>
<tr>
<td>Out-patients and outside visits</td>
<td>9,547</td>
</tr>
</tbody>
</table>

Total Expenses for the Year, Mex. $8,459.38.

In the Report of the previous year, reference was made to the departure of Dr. B. Score Browne from China for military service in Europe. He has since won the distinction of the Military Cross, for
"conspicuous gallantry and devotion to duty." After his departure, Dr. A. F. Cole, his colleague, felt that he also must volunteer for active service in response to his country's call, and so left for England, June, 1915. The hospital work was kindly taken over by Dr. E. G. Sugg, the Port doctor.

Strong efforts are being made to secure the interest of the officials and gentry in the hospital with view to making it more financially independent of foreign support. Their local subscriptions enabled the staff to close the year without a deficit, despite the increased cost of drugs, and the expense of extensive repairs made necessary by a severe typhoon.

In the hospital, "it has been a year of steady work; the number of in-patients is about the same as last year, notwithstanding the closing of the hospital for six weeks for internal repairs at the Chinese New Year. Operations are above the average. There has been, however, a big drop in the number of out-patients, which may be accounted for by the present system of charging each patient a small sum for medicine, and there were no Settlement patients, but I think the main reason is the opening of a hospital by a foreign-trained Chinese doctor in one of the main streets about half a mile away. Besides, last autumn no country dispensaries were held because of our reduced staff; this would make a difference of several hundred. Still we are not downhearted, for nearly ten thousand people is a goodly number to reach each year, with relief of physical pain and suffering, and with the message of salvation from sin and death."

Dr. Sugg describes several very interesting surgical cases, and notes that "the particular branch of medicine in which the foreign physician individually excels becomes speedily known among the Chinese. Probably there is no country where a man's reputation spreads faster than in China. This is easily demonstrated by a comparative scrutiny of the surgical procedures in different hospitals where there is a predominance of certain operations."

Besides being hospital superintendent, the Rev. H. Barton undertakes the burden of the evangelistic work in the hospital and the financial control of affairs.

William Gamble Memorial Hospital for Women and Children, Chungking, West China.

Staff:—Lillian L. Holmes, Superintendent; Agnes M. Edmonds, M.D., Physician and Surgeon; Native Student Nurses, 10.
STATISTICS:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Beds</td>
<td>...</td>
</tr>
<tr>
<td>Patients</td>
<td>...</td>
</tr>
<tr>
<td>Dispensary Patients</td>
<td>...</td>
</tr>
<tr>
<td>Obstetrical Cases</td>
<td>...</td>
</tr>
<tr>
<td>Out-calls</td>
<td>...</td>
</tr>
<tr>
<td>Surgical Operations—Major</td>
<td>...</td>
</tr>
<tr>
<td>Minor</td>
<td>...</td>
</tr>
<tr>
<td>Total expenditure for the Year, U. S. Gold</td>
<td>$2,230.47</td>
</tr>
</tbody>
</table>

The Report opens with a brief account of the hospital work of the past twelve years, followed by a biographical sketch of each of the Chinese members of the staff. Several interesting medical and surgical cases are described, among them being successful Caesarian sections, and the removal of a tumor 159½ lbs. weight, the patient making an uneventful recovery notwithstanding that she had to break the opium habit at the same time. Full particulars are given of the training school for nurses in connection with the hospital. Evangelistic efforts form a happy and prominent feature of the whole work.

Westminster Sunday School Hospital, Changteh, Hunan.

This building has recently been completed at a cost of about $15,000 Mex. The dimensions are: Main building, 30' × 130'; Surgical wing, 30' × 35'.

Besides the two main floors, there is a basement six feet high, and an attic that is high enough to give head room over most of the floor. Three superimposed glazed ventilators over the attic give light and ventilation and make this place very roomy and comfortable for the hospital assistants and helpers.

The problem of diversifying the front of the building so as to give a pleasing appearance, has been most happily solved, I think, by Mr. Stanley Wilson, Supervising Architect of the Yale Mission, who kindly furnished the drawings for the veranda, which in this case practically makes the front elevation.

The inside arrangements are extremely simple. There is an entrance hall, which serves as a guest room also, 22' wide, in which is a double stairway. On either side of this hall is a ward, and at each end of the building there is a private room and a nurse's room.

In the "Surgical Wing," which is in the middle of the building at the back, there is located on the ground floor, the drug room, laboratory, and a large dressing room. The second floor of this wing
is entirely taken up by two operating rooms, the skylights of which are a part of the roof of the north side of the building.

All the surgical dressings are to be done in the dressing room below or in the minor operating room above. The plan is to have the assistants arrange the patients in these rooms and loosen the dressings so that the doctors may look at the cases in a very short time, give orders and then go about their other work. These rooms are heated and provided with six operating or dressing tables that fold up against the wall when not in use. If necessary, a patient can be brought in on his own bed by means of a bed mover.

In fair weather the beds can be rolled on to the veranda. The door sills of all parts of the building are on a level with the floor, so as to facilitate the moving of beds and ward carts.

The normal capacity of the hospital is 80 patients.

O. T. LOGAN.

Note.—The photograph of the hospital which appears as the Frontispiece in this number of the Journal was made with a "pinhole camera" which, as many readers know, is simply a box with a sheet of thin metal tacked to the front. In this metal sheet is punched a hole, which when smoothed down, takes the place of a lens. In our case the hole was 1/50 in. in diameter and the plate, 8" x 10", was placed three inches from the aperture. On account of the nearness of the building to the front wall we could get the picture of the front in no other way. The exposure was fifty seconds on a bright day at 3 p.m.

O. T. L.

Medical and Surgical Progress.

Internal Medicine.

Dr. Edward H. Hume, Changsha, Hunan.

Treatment of Hay Fever.—After a most suggestive and thorough review of the early investigations into the nature and treatment of hay fever—carried back to the comments of Botallus in 1565, ("For there are many who are attacked by sneezing by the slightest thing whatsoever, others by merely smelling a rose")—Hitchens and Brown present a summary of their own work, giving methods and results. The latter are most encouraging. (Journal of Laboratory and Clinical Medicine, 1916, i, 457). Flowers are gathered just when pollination has started, and the pollen from the flowers is collected by means of fine sieves. It is thoroughly dried and kept so until it is to be extracted. Extraction is a somewhat lengthy process, done with physiological saline solution, purification being accomplished by means of acetone which precipitates the extracted protein. Finally, redissolved in physiological saline, the solution is so diluted that each cubic centimeter will contain certain fractions of a milligram of protein-nitrogen. In the lowest dilution, 1 cc. of which.
is used as the initial dose in treatment, there is 0.0025 mg. These final solutions are treated with tricresol and sterilized by filtration.

Treatment is begun with the above dose and continued with increasing multiples of that amount according to the needs and sensitiveness of the patient. Injectious are given at five-day intervals at first, shortened or lengthened as the patient shall require. Ophthalmic reactions are not advised and even skin tests are regarded as complicating the process for the clinician. In other words, a satisfactory dosage can now be arrived at without the need for the ophthalmic or skin control.

Of 62 cases carefully recorded and studied by the writers, 18 had asthma as a complicating symptom.

Of these 18 cases, 3 sent no report; 1 was not relieved; 3 were considerably relieved; 11 were entirely relieved.

Of the remaining 44 cases, 3 gave no report; 2 were not relieved; 4 were slightly relieved; 18 were considerably relieved; 17 were entirely relieved.

Two types of extracts were used. The “Spring” extracts contained a mixture of the pollens of red top timothy, rye, and orchard grass; the “Autumn” type consisted of ragweed alone. One patient not completely relieved by the “Spring” vaccine was found susceptible to daisy pollen. A special daisy vaccine was prepared and the administration of a single dose brought complete relief. In some cases it is necessary to determine the presence or absence of bacterial infection. Two patients unrelieved by pollen vaccine, were cured after the use of Micrococcus catarrhalis vaccine.

The writers conclude with an interesting discussion of the entire problem. They regard hay fever, at present, as a problem of immunology and chemistry. While the question as to what essential constituent of pollen should be contained in the extract is still a matter for debate; and while it is quite apparent that individual patients differ in their susceptibility to various pollens, still, certain practical lessons have been learned from what has been done already, bearing on the treatment of sufferers. In the first place, if possible, measures should be instituted two or three months before the hay fever season, to determine all the flowering plants in the patient’s habitual surroundings which might reasonably come into question. Skin tests should be made with the pollens of each of these to determine which is responsible. Secondly, if the attack has already started, treatment should be begun at once with a vaccine representing the pollens most likely to be responsible. If the treatment does not give entire relief, an exact diagnosis may be made independently of the treatment.

Chemical versus Serum Treatment of Epidemic Meningitis.—The reappearance of epidemic meningitis among the belligerent armies of Europe led Flexner and Amoss (Journal of Exper. Medicine, 1916, xxiii, 683) to undertake an investigation into the worth of the so-called chemical treatments for this disease, especially lysol and protargol. They point out that chemical treatment, theoretically viewed, might promise success. The infection is localized within the cerebrospinal membranes, and these are accessible directly from without so that the chemical substance can be brought into immediate contact with the infectious material. Further, the meningococcus outside the body is readily destroyed by chemical action. Careful experiments were made on
The China Medical Journal.

guinea-pigs and monkeys to determine whether these theoretical considerations would prove valid in actual cases of infection by meningococcus.

Neither protargol nor lysol displayed any curative action on experimental infection produced in the test animals. On the contrary, "both lysol and protargol exert antileukotactic and antiphagocytic effects, and are also potent protoplasmic poisons, and the leukocytes with which they come in contact are injured and made to degenerate." "Recovery from meningococcic infection in man and animals is accomplished chiefly through the process of phagocytosis. The specific antiserum acts curatively by increasing the emigration of leukocytes, by promoting phagocytosis directly, and by agglutinating the meningococci and also by neutralizing endotoxin. Any means which interfere with and reduce these essential processes retard or prevent recovery. "Specific antiserum seems to provide the logical therapeutic agent with which to combat epidemic meningitis, since it is itself innocuous and promotes those processes essential to recovery from the disease. The problem up to the present has been that of producing an antiserum which represents the several types of the meningococcus and this problem is now in fair way to be solved."

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Therapeutics.

ON THE TOXICITY OF VARIOUS COMMERCIAL PREPARATIONS OF EMETIN HYDROCHLORID. — According to R. L. Levy, M. D., and E. G. Rowntree, M. D., (Bulletin of Johns Hopkins Hospital, February, 1916), the widespread use of emetin hydrochlorid in the treatment of amebic dysentery and of pyorrhea alveolaris makes desirable more precise knowledge of the toxicity of the commercial preparations employed. Two cases occurring in the medical service of Johns Hopkins Hospital during the past year forcibly emphasize this fact.

The first case was that of a syphilitic man of 56, who, because of a diarrhea, supposedly amebic in origin, was given, hypodermically, 29 grains of the drug over a period of 20 days. He died ten days after discontinuing the emetin treatment, with evidences of acute renal insufficiency accompanied by acidosis. At necropsy, syphilitic aortitis, chronic indurative colitis and broncho-pneumonia were the only findings of importance. In the second case, 2 grains were given hypodermically, during a 4-day period, to an undernourished anemic woman suffering from a severe grade of pyorrhea and gingivitis. A severe diarrhea developed, with pus and blood in the stools, followed by a toxic delirious psychosis. On discontinuation of the emetin recovery ensued.

A dog was injected subcutaneously with some of the same preparation employed in the second case, and died with a hemorrhagic gastro-enteritis, after three doses of 10 mg. each, given on successive days.

Subsequently, studies were made on 62 animals, the series including dogs, cats, and rabbits. Five commercial preparations were investigated. Injections were made both subcutaneously and intravenously. The following facts were brought out:
1. Various commercial preparations differ widely in toxicity. The therapeutic dose (mg. per kg.) closely approximates that necessary to produce toxic symptoms.

2. When intravenously administered emetin is a powerful cardiac poison, causing at times fibrillation of the ventricles, from which the animals may recover. It is also a circulatory and respiratory depressant.

3. In fatally poisoned dogs the characteristic lesion is a hemorrhagic gastro-enteritis. Lesions in cats and rabbits are slight and inconstant.

4. The factors of blood coagulation are disturbed in poisoned animals.

5. There is found no evidence of renal insufficiency; a slight terminal acidosis is present.

On reviewing the reported cases in which ill effects have followed the clinical use of emetin, it is apparent that diarrhea is an early toxic manifestation and that peripheral neuritis is one of the most frequently observed sequelae, even after the administration of therapeutic doses.

As a result of these observations, it is suggested that emetin preparations be employed with caution. It is desirable that the drug be given subcutaneously, in courses, at intervals of several days or a week. A third of a grain three times a day, for a week or ten days, is usually a safe dosage in amebic infections. According to Bass and Johns, half a grain daily for from three to six days suffices in pyorrhea. Large doses should be avoided. Intravenous injections should be employed only in extreme cases. If this mode of administration seems imperative, small doses, well diluted (gr. ss. in 100 cc. salt solution) should be slowly given, and the blood pressure should be carefully observed during the injection.

**Chenopodium in the Treatment of Uncinariasis.**—In the *Journal of the American Medical Association* of November 6, 1915, Bishop and Brosius reach these conclusions:

1. The method of administration of chenopodium is simple, and is attended with less inconvenience and discomfort than is thymol. This would give the drug an important place in the field work in uncinariasis.

2. Chenopodium can be given at shorter intervals than can thymol, and a cure can thereby be more quickly established, which gives it a greater economic value.

3. Chenopodium is non-toxic in therapeutic doses.

4. Chenopodium is a more efficient vermifuge than thymol in the treatment of uncinariasis.

**Chaparro Amargosa in Amoebic Dysentery.**—This drug, long used as a domestic remedy in S. W. Texas, has been employed by Nixon (*Amer. Jour. Trop. Dis.* Vol II, No 9) in amoebic dysentery. It belongs to the *Simarubaceae*, and its botanical name is *Castela Nicholsoni* (Hook). Its common name is bitter-bush. All parts are bitter to taste and seem to be efficient medicinally. There is a fluid extract on the market, but Nixon uses a fresh infusion or decoction of the whole plant. Clinically, it resulted in prompt improvement of the stools, which became normal in a couple of days. He used it as follows: After preliminary administration of magnesium sulphate, six to eight ounces of the infusion are given thirty minutes before each meal, and rectal enemata of 500 to 2,000 c.c. twice daily in the
knee-chest position. The patient is instructed to retain the enema as long as possible. The treatment is continued for a couple of weeks after the symptoms subside. Experiments show that, in vitro, the drug even in weak solutions has a special affinity for the protoplasm of Entamoeba histolytica. Thus a detannated fluid extract in the strength of 1-10,000 causes immediate cessation of movements, and the amoeba assumes a spherical shape with sharp differentiation of ectoplasm and endoplasm. A solution of 1-100,000 acts in forty seconds, and 1-1,000,000 in two minutes. The action seems a specific one on the Entamoeba histolytica, as the drug is not curative in ordinary dysentery or in other parasitic affections.

The Uselessness of Strychnine in Heart Failure.—Many clinicians prescribe strychnine in acute and chronic heart failure because they believe that it increases the work of the heart and that it slows and steadies the pulse. Yet there is no sound basis for this belief. Pharmacologists have not been able to demonstrate that strychnine increases the output from the heart. Clinicians have not shown that broken cardiac compensation can be relieved. Sir James Mackenzie, discussing "cardiac tonics," has written: "The most popular remedy of this class is strychnine. I have carefully sought for its special effect on the heart and found none. The evidence is practically all clinical, and endows the drug with the most diverse properties. It is recommended as a cardiac stimulant in slow hearts, and even in heart-block it is said to quicken the beat. It is also recommended in the too excitable heart, as when there are extra-systoles, and in the rapid heart of acute myocardial affections. It is said to be beneficial in cases of low blood-pressure and equally beneficial in the cases of high tension and even in angina pectoris."

Parkinson and Rowlands investigated the action of strychnine in 50 cases of severe heart failure with the polygraph and manometer. Readings were taken before and after injection of 1/15 gr. of strychnine sulphate. In no case was there any effect on the pulse-rate or blood pressure, or the rate and amplitude of the respirations. In the cases of auricular fibrillation, no effect was produced on the irregularity.

As the evidence that a single dose of strychnine is not beneficial in heart failure does not prove that its prolonged use may not be so, the writer investigated the effect of large doses given for several days in chronic heart failure. The investigation was confined to eight patients who did not recover compensation after rest in bed. Strychnine was given in doses varying from 0.03 to 0.1 gr., and in some cases, toxic effects were produced. None of the patients was benefited, though four subsequently recovered compensation under digitalis.

Conclusion.—Neither pharmacological nor clinical evidence justifies the use of strychnine in acute or chronic heart failure.—American Journal of Medical Science.
Post-partum Care of the Perineum. In the Johns Hopkins Hospital Bulletin, April, 1916, Dr. E. D. Plass, Instructor in Obstetrics, Johns Hopkins University, holds that the use of antiseptic solutions in the care of the perineum during the puerperium, and in the after-care of primary perineorrhaphies, is of no value. He states that the present treatment of the perineum both after uncomplicated labor and after primary perineorrhaphy appears to have descended from the antiseptic period, when any addition to the chemical armamentarium was hailed as a panacea. It would seem that obstetricians have been so absorbed in determining the proper time for, and the technique of, repair, that the old antiseptic after-care has been handed down unchanged to the present generation. Only occasionally a sceptic like Krönig has dared to doubt the value of these time-honored customs, but in the course of time all of us will be led to consider critically the value of antiseptics, and determine to what extent they are useful.

When it is realized that, with the exception of iodine, the usual antiseptics, in concentrations in which they can safely be used on the skin, destroy the usual pathogenic organisms only after a long period of activity, does it appear reasonable to expect that the ordinary irrigations and douches will have more than a mere mechanical action? The false sense of security engendered by the term "antiseptic" is dangerous, and when untoward results follow, many individuals seemingly prefer to lay the blame upon the solutions rather than upon their own slip-shod methods. To the average nurse the term "antiseptic" spells safety, and she trusts implicitly in the germicidal action of a 1:1000 or a 1:2000 bichloride solution. By eliminating the use of such solutions we do away with this false sense of security, and in my experience the results will be as good or better than those formerly obtained.

There is practically no recent literature upon the routine postpartum care of the perineum, or the after-care of primary perineal repairs. In order to ascertain the general sentiment of the obstetricians of this country in this regard, various text-books of obstetrics were examined with the following results:

E. P. Davis (Manual of Obstetrics, 1914) advises "a copious irrigation by a small pitcher with an antiseptic solution," during the puerperium, and "pouring 1% lysol or sterile salt solution from a pitcher over the parts after each micturition or defecation, and whenever the vulvar dressing has become soiled and has been removed" in the after-care of cases with suture.

Hirst (Text-Book of Obstetrics, 7th edition, 1914) says: "Care must be exercised to remove blood and blood clots from the vulva before putrefaction sets in. This is best done by placing the woman on a bedpan, letting a stream of boiled water run over the parts, and, if necessary, using cotton to wipe them off." No reference to any special care after perineorrhaphy was found; but since Hirst advises making all repairs at the end of one week, one can scarcely speak of primary repair.
Henry F. Lewis, in the *Practice of Obstetrics*, edited by R. Peterson, 1907, advises "irrigation with sterile water or sterile antiseptic solution, finishing by drying with some sterile gauze." He mentions no special care following repair.

De Lee (*The Principles and Practice of Obstetrics*, 1913), under "Aseptic care during the puerperium," says: "The patient is placed on a sterile bedpan, the nurse sterilizes her hands or wears sterile gloves, and gently pours from a narrow-lipped pitcher a solution of 1:2000 bichloride of mercury over the vulva. The excess is dried off without rubbing, by touching with dry sterile cotton . . . . Simple sterile water may be used." After repairs no special care is recommended.

Without exception the text-books examined recommended cleansing at frequent intervals with antiseptic solutions, with sterile water or with saline solution, and frequently the procedure was made very elaborate and time-consuming. There seems to be a widespread belief that some extra care is needed, but the variations in treatment have to do only with the choice of the solutions and in the method of their use.

In order to demonstrate whether such routine antiseptic treatment of the perineum after delivery has any distinctly beneficial effect upon the course of the puerperium or upon the healing of primary perineal repairs, the following clinical experiment was conducted. For a period of nine months—from November, 1914, to August, 1915,—all patients were divided into two groups after delivery, A and B (every alternate patient being placed in group A), and treated as follows: Those in group A were given the routine perineal care and those in group B were given no special attention. The routine care consisted in bathing the vulva and perineum with cotton pledgets soaked in 1:2000 bichloride of mercury solution every four hours, as well as after each defecation and urination during the nine days the patient remained in bed. The patients in group B were merely kept macroscopically clean with warm tap-water and soap and a wash cloth. No attention was paid to voiding or bowel movements, unless, as sometimes happened after the initial dose of cathartic, the need of cleansing the parts was apparent. The bloody lochia were removed whenever necessary. Unless the patient was very ill, she was expected to keep herself clean.

It was found that the average number of cleansings necessary was as follows: Four a day for the first three days; between the third and sixth days not more than two a day, and after this only one, at the time the morning bath was taken.

Every effort was made to eliminate any factors which might invalidate our conclusions. Since the two series were run simultaneously, the factors of nursing care and surgical ability in repairing the lacerations on the part of the house staff were removed as nearly as possible. The head nurse arranged the lists impartially and none of the staff knew how any particular patient was being cared for. No exceptions were made to the alternate grouping of the patients. At the end of the experiment, when each group contained 200 cases, the records were carefully tabulated and the following facts discovered:
vaginal examinations are made only for the purpose of instructing students. These, however, probably account, in part at least, for the rather high morbidity, particularly that referred to uterine infection. Fortunately, none of the infections were severe, and there was no mortality.

The number and character of the repairs of lacerations, as well as the conditions which obtained at discharge (12 to 14 days after labor) are shown in Table B. No particular scheme of repair was insisted upon, but all perineorhaphies were made with catgut and silk-worm gut, either singly or in combination. Very small nicks were frequently not repaired.

Reference to Table A shows that the two series are quite comparable as regards operative deliveries and the frequency of vaginal examinations, the two factors which might possibly have had a bearing on the results. The total morbidity (temperature over 100.4°F., taken every four hours) is approximately the same (group A, 39.5%; group B, 36.0%); nor is there any striking difference in the incidence of elevation of temperature attributable to uterine infection, as determined by uterine cultures or by the clinical course of the puerperium (group A, 15.0%; group B, 14.5%). The advantage, if any, is in favor of the series not especially treated (group B).

The low percentage of vaginal examinations is attributable to the fact that the staff attempts to follow the course of labor by means of abdominal palpation and rectal examination, so that ordinarily it will be noticed at once that there is a considerable difference in the results obtained. The routine care was followed by many
poor results, whereas excellent results were obtained where no antiseptic precautions were taken. Of special interest is the one case of complete laceration—a forceps delivery of a child weighing 5,000 g. in the case of an 18-year-old primipara. She chronologically went into the "no care" list, and the supreme test was made. The healing was per primam, and not only was the sphincter tone excellent, but the perineal body was also in good condition. When one sees a poor result in only 12 out of 400 cases there is a tendency to be satisfied; but a comparison of the results obtained in the two groups—14.3% and 4%, respectively—clearly indicates that too many failures occurred in group A.

This method of treatment was so successful that on August 1, 1915, the old routine was entirely abandoned. Since that time 57 primary perineorrhaphies have been done as follows: 1st degree, 32; 2d degree, 17; and episiotomies, 8, with only three bad results (5.25%), and these were confined to the first degree tears. The episiotomies were all lateral, single or double, and the wound healed per primam.

To date we have treated 108 repairs in this manner and have had five failures, a percentage of 4.6.

In addition to the better results obtained after the elimination of the more or less complicated antiseptic treatment, there is an economy in the time of the nurses. All who have to do with nursing in large institutions will welcome any change which will free the nurses from the burden of unnecessary routine and give them time to really nurse the patients, provided the result is satisfactory.

Conclusions.—The use of antiseptic solutions in the care of the perineum during the puerperium or in the after-care of primary perineorrhaphies is of no value. Macrosopic cleanliness alone gives better results and effects a considerable saving of time."

Note.—Since November, 1914, the antiseptic after-care of secondary perineorrhaphies done in the gynecological service has been discontinued and no attention is now paid to the wound in these cases. Dr. V. N. Leonard, resident gynecologist, has assured me that the results are excellent; and that, although no statistics have been compiled, the percentage of poor results is even less than previously. The absence of bleeding makes it unnecessary to resort to any special cleaning of the perineum so that the only attention consists of the usual morning bath. Vulvar pads are discontinued after two days.

Tropical Diseases.

Failures in Clinical Diagnosis.

In an instructive article entitled, "Surprises for the Diagnostician revealed by the Pathologist," New York Medical Journal, May 13, 1916, W. G. Baetz, M.D., formerly Physician, Ancon Hospital, Canal Zone, Panama, draws attention to a collection of more or less exceptional failures in clinical diagnosis, from which the following cases are selected because of their bearing on the diagnosis of tropical diseases.

Malaria: Infection from Hypodermic Injection. A young negro adult was admitted with a serious infection of estivoautumnal malaria. He was given bihydrochloride of quinine by hypodermic injections and died on the sixth day. The diagnosis of estivoau-
Tropical Diseases.

Tumunal malaria received a bad blow when a gas bacillus infection was found at necropsy to be present in the quinine hypodermic site in the left thigh. The clinician had probably paid too little attention to the pain the patient had complained of following the injection of the quinine.

Pellagra: Diphtheria. Another adult negro was sent to the hospital with the provisional diagnosis of pellagra. He gave a history of having been ill for a month with dysentery and a sore mouth. The physical examination revealed an exudative stomatitis and pharyngitis. There were no visible ulcerations, but the gums were spongy and bleeding. The patient was very toxic. Perianal excoriations were present. The tongue was denuded and fiery red. In view of the history and these findings, the provisional diagnosis of pellagra seemed justifiable, even in the absence of a dermatitis. Before further examination could be made this patient had a convulsion and died unexpectedly twenty-four hours after admission. The autopsy seemed to corroborate the clinical diagnosis of pellagra until the cultures taken post mortem proved the case to be a most unusual diphtheria infection.

Malaria: Typhoid Fever. The following case shows how easily one infection obscures another. This patient was admitted in a comatose state with a temperature of 104.5°F. A blood film showed the rings of estivoautumnal malaria. An hour later the patient died. The autopsy proved the malaria infection, which was chronic, but also showed that the acute illness causing death was typhoid fever and not malaria. This danger of attributing a patient's illness solely to the malarial parasites that may be found in his blood is always present in those parts of the tropics where practically all natives harbor parasites.

Malaria: Cerebral Syphilis: Septicopyemia. A case of septicemia was diagnosed cerebral syphilis and estivoautumnal malaria. The clinical diagnosis was undoubtedly correct, as far as it went, for the asexual parasites of malaria were found in the blood films of the patient and his Wassermann test was positive. The presence of facial palsy, Kernig's sign, ankle clonus, paresthesias, anesthesias, and coma pointed to central nervous disease. Nevertheless, the pathologist showed that, without doubt, death was due to septicopyemia. The original focus of the purulent infection, unknown to the clinician, was found to be a chronic, solitary ulcer in the cecum.

Malaria: Meningitis: Ulcerative Colitis. Another case of septicopyemia in this series was diagnosed clinically as pernicious malarial fever and meningitis. It is highly improbable that any previously untreated patient will die of malarial fever whose blood film, carefully stained and examined, fails to show the parasite. This case was diagnosed pernicious malaria in the face of negative blood findings. Another factor in the failure of diagnosis was the inadequate examination of the feces. The fatal pyemia was caused by an extensive ulcerative colitis, acute and chronic. A single microscopic feces examination was charted as being negative. A white blood count of 7,000 seems to have prejudiced the clinician against a purulent infection hypothesis.

Malaria: Meningitis: Cystic Parencephalus. A tropical negro boy, seven years of age, was admitted in a semicomatose state. The history given by the mother
was that he had been sick for three
weeks with palsy of the left arm
and leg. Ten hours before seeking
hospital treatment the boy had
begun to vomit and had lapsed into
semicoma. When roused he spoke
disconnectedly and in a decidedly
slurring fashion. The white blood
count was 13,600. The thermometer
registered 100° F. After a
tedious search, estivoautumnal para-
sites were found in the patient's
blood. We read of a good deal of
pernicious malaria producing local
palsies and hemiplegias, but the
pathologist usually finds a better
explanation for such definite focal
signs. Keeping this bit of experi-
ence in mind, we subjected the
patient to a spinal puncture in
addition to treating him for per-
nicious malaria. Although the
cerebrospinal fluid proved negative
both in culture and cytology, the
pressure was so decidedly increased
that when the patient died on the
third day, a diagnosis of simple
meningitis was given preference
over the malaria diagnosis. The
autopsy brought to light a cystic
parencephalus involving the pons,
crus cerebri, medulla, and cervical
portion of the cord. Internal
and external hydrocephalus were
marked. A chronic malarial infec-
tion with a few parasites in the
spleen and the bone marrow was
found, and the possibility of another
delusion concerning malarial hemi-
plegia had been dispelled by the
pathologist.

Dysentery: Syphilis: Leprosy.
Among gastro-intestinal cases, the
first was correctly diagnosed as
clinical dysentery, a term we have
adopted for dysenteries in which
the causative factor cannot be
found. The shock of surprise
imparted to the clinician by the
pathologist came about by the way
of a secondary diagnosis. The
patient, a senile negro, presented
complete destruction of the nasal
bones and adjacent structures. As
evidences of an old syphilitic infec-
tion were plentiful, no hesitation
was felt in making a diagnosis of
tertiary syphilis as the secondary
cause of death. A rude awakening
took place among the clinicians,
who had thought themselves per-
fectly safe in their diagnosis, when
the pathologist found the necrotic
tissues and the right ulnar nerve to
be thickly settled with the bacilli
of leprosy.

Typhoid Fever: Clinical Dys-
entery. In the next case, a
clinical diagnosis of typhoid fever
was made in a patient who died on
the fifth day. The high temperature,
the low blood count, a suspicious
Widal, and a large soft spleen
formed the evidence elicited by the
internist in the support of his diag-
nosis. Against this were noted the
presence of pus and blood in the
stools, a negative blood culture,
and death approaching with a fall-
ing temperature curve. Clinical
dysentery was the cause of death
given by the pathologist. This
case belongs to a class of exceed-
ingly fatal dysenteries in which the
undoubtedly present bacillary cause
has not been isolated as yet.

Hepatic Abscess mistaken for
Carcinoma, Congestion of the
Liver, Typhoid Fever, Pneu-
monia, Chronic Nephritis. The
hepatic group of failures consists
entirely of four cases representing
a tropical and subtropical disease
manifestation that is the bane
and the fear of the internist. It
is as elusive as it is destructive.
I have reference to entamebic
abscess of the liver, the early diag-
nosis of which often means every-
thing to the sufferer. Spontaneous
recovery is so rare that a failure to
diagnose this affliction is practical-
ly always fatal to the patient. In
selecting these four failures we are
impressed with the variety of conditions for which hepatic abscess is mistaken. This is not surprising when we consider that there is no definite symptom complex of this curse of the tropics that is not found more often in other causes of hepatic enlargement. Until diagnosis by röntgenology and a serum ferment test become practical possibilities, there will always be patients slowly dying under our very eyes, in whom past history as to dysentery, temperature records, physical examinations, the absolute and the differential blood count, stool examinations, aspiration of the afflicted organ, and even exploratory laparotomy have deceived us. Here is a case of a huge, solitary abscess in an old man. A subnormal temperature, extreme emaciation, a large hard, nodular, insensitive tumor, and abdominal glandular enlargement and induration, a white blood count of 8,000, with a negative dysentery history, made an exploratory laparotomy appear needless cruelty in a case where carcinoma seemed certain. Necropsy was humiliating. Another is mistaken for passive congestion of the liver in a cardiac dilatation case. A third is one in which the high temperature reaction with a low blood count in conjunction with severe toxic stupor was taken for typhoid infection. When the abscess in the hepatic dome caused the lower pulmonary lobe to collapse, bronchial breathing was heard. A white blood count that had risen to 20,000 seemed to clinch the secondary diagnosis of complicating pneumonia. A fourth case in which aspiration of the liver was negative, gave the same pulmonary signs and lobar pneumonia seemed probable, the enlarged liver being explained by the usual cloudy swelling of that organ in pneumococcus infection. When the high temperature gradually came to normal and remained there, but the solidified pulmonary base did not become aerated, an unresolved lobe was suspected in a patient seemingly dying from chronic diffuse nephritis. It is in this class of cases that the diagnosis may mean life or death to the patient. The brevity of the notes on clinical progress in some of the records leaves the disquieting impression that at times insufficient attention, bordering on neglect, is accorded these most important cases.

MALARIA: SPLENIC ABSCESS. The spleen, independently, is not often the site of morbid processes. The one case selected was diagnosed pernicious malaria, the patient being admitted in coma with parasites in his blood. Death occurred within eight hours. At autopsy the malarial infection was found to be of secondary importance. A large splenic abscess communicating with the colon was the undoubted cause of death.

SARCOMATOSIS: SYPHILIS: DYSENTERY. A misinterpreted sarcomatosis occurred in an adult negro suffering with advanced syphilis and entamoebic dysentery. A large sarcomatous nodule was found by the clinician "to be protruding from the prostate into the rectum. The rectal mucous membrane over the nodule was ulcerated and it was from this ulcer that the diagnosis of entamoebic dysentery was made microscopically. Unfortunately for his complete diagnosis, the clinician mistook this ulcerating nodule for a broken down gumma that had become infected with entamoeba. Both the entamoebic dysentery and the tertiary syphilis were verified at autopsy, but the actual cause of death was sarcomatosis.
Public Health Education in China.

Dr. W. W. Peter, Shanghai.

PUBLIC HEALTH CAMPAIGN IN CHENGTU. In a letter dated July 14, 1916, Dr. C. W. Service, of the Canadian Methodist Mission, Chengtu, Szechwan, writes as follows: "Last fall we organized a strong campaign committee which worked for weeks on the detailed plans for a monster Public Health and Social and Moral Reform Campaign. We had everything arranged down to the minutest detail and were all ready to commence in February on a four months' campaign covering eight subjects when the troubles began in this province so that we had to call the whole thing off until a later date. Our province is still much disturbed. This is especially true of Chengtu. We hope quiet may soon prevail and that by the early fall we may be able to start in on our intensive campaign as arranged before. However, we have not been idle in this line of work. Many thousands of Anti-tuberculosis Calendars have been disposed of. At least fifteen thousand were bought by us in Chengtu and these are nearly all sold. I have sold several thousands in the dispensary. Dr. Irwin sent a man out on the street who sold several thousands. Further, on two occasions we organized a number of groups of Chinese and foreigners and "did" the city in an afternoon. On these two occasions we took Anti-tuberculosis Calendars, Anti-fly Tracts, and Anti-cigarette Tracts and Posters. As a matter of fact what we have done so far is merely sporadic as compared with the definite campaign we hope to carry through later. We have a list of over twenty subjects. The present thought is to carry through three separate campaigns, each covering four months, two weeks to be devoted to each subject. Lectures, posters, tracts, sandwich-men, lantern slides, newspapers, charts, etc., will be used. Indeed we already have a tolerable anti-tuberculosis display in the Y. M. C. A. I do hope we can carry our plans through successfully. Our present scheme will cover at least a year and a half. We shall have to prepare most of our own literature, and that is a big job for busy men. I have already finished a 2,000 character anti-tuberculosis folder, also a big anti-cigarette poster and an illustrated tract on the same subject. Fortunately up here almost the entire missionary body is against the cigarette. Thus we have no trouble in putting through campaigns on this question.

I hope that in the months to come I shall have something really interesting to write you about our work along this line. We do not lack ideas or plans, but unfortunately we have to hold them largely in abeyance for the present until our city and province become more stable."

TUBERCULOSIS POSTER.—Dr. F. J. Tooker wishes to thank the doctors who responded to his letter of inquiry regarding Tuberculosis Poster, for their splendid cooperation. He received some very helpful criticism and good suggestions, which he hopes to incorporate in the new edition of the Poster which will appear in the near future. Notice will appear in the Journal.

TRACHOMA.—In the May number of the Journal, Dr. Bryan-Brown of Peking drew attention
to the deplorable prevalence of trachoma in the northern part of China. In the United States, where the disease is largely introduced by the poorer immigrants from Italy, Poland, Russia, Syria, Turkey, etc., the subject has become of special importance, and the National Committee for the Prevention of Blindness has just issued a powerful pamphlet showing the prevalence of trachoma in the States in order to arouse public opinion on the matter. The following advice to patients with trachoma has been circulated all over America, and, with a few changes perhaps, it might be well to circulate similar recommendations for the benefit of the Chinese.

Apply at once for treatment to the nearest hospital, dispensary, or to your own physician.

Follow the directions of the doctors and nurses as to treatment and prevention.

Wash your face and hands several times a day and keep the finger nails clean.

Never touch your face with your hands, unless they are absolutely clean.

Boil your handkerchiefs before adding them to the wash.

Do not allow your clothing or bed-clothes to become soiled with the discharges (pus) from your eyes.

When your eyes are discharging pus, collect the discharges on cloths which can be burned, and stay away from other members of your family as much as possible.

Sleep alone and with the window open.

Keep your home clean, and have large windows to let in the fresh air and sunshine.

Do not stop treatment until you are cured.

Keep in good physical condition.

Have large windows in your homes, which will admit plenty of fresh air and sunshine.

Sleep with your windows open, even in winter, and keep the room well aired where you live and study.

Do not use the family towel, especially in homes where there are cases of trachoma.

Have your own towel and handkerchief and don’t let anyone else use them.

Always make sure that the wash basin is clean before using it.

Do not sleep with persons having sore eyes, nor use bedclothes that have been used by them.

Do not wear the clothing of others, nor use their eating utensils without previous cleaning.

Advise anyone with sore eyes to have them treated at once.

Practically the same recommendations have been made by the surgeons in India and they have further adopted the expedient of printing large posters, which have been tacked in prominent places on all reservations, and at the schools, calling attention to the dangers from trachoma, the means of conveying the infection, and health hints in simple language.

HOUSE TO HOUSE SANITATION IN HONGKONG. Even more important than the cleaning of the streets is the cleansing of the dwellings of the poorer classes of Chinese, and this work is now coming to occupy most of the energies of the Sanitary Department. Tanks of soap and water are provided in the streets for the respective blocks of houses, and notice is served on the inmates that their houses must be cleansed by a certain day,—when all floors, rooms and cubicles must be cleared out and they with their furniture ready for inspection. If a house is not clean the cleansing gang takes charge of it and cleanses it thoroughly. The District Inspectors then carefully inspect all houses and furniture, and take note of any nuisances and illegalities, which in this way can be systematically dealt with. So useful have these cleanings been found that it is now intended to increase them.

In addition to the house cleanings done by the Sanitary Department all tenement houses are whitewashed by their landlords once a year according to law.—Hong kong Medical and Sanitary Reports.

On the basis of comparative studies on a number of representative animals the author reaches the conclusion that the dorsal musculature of vertebrates is differentiated in its phylogenetic development primarily into an ilio-costal and a combined spinalis-longissimus system. The latter ultimately becomes separated into its component parts, the longissimus and the transverso-spinals systems, which theoretically can be differentiated into semispinalis and multifidus groups. The author believes that the so-called semispinalis capitis or better the transverso-occipitalis of mammals is in reality a remnant of the earlier spinalis-longissimus system, while the longissimus cervicis et capitis, for which the earlier-used name transversalis cervicis et capitis is proposed, shows a muscle of the ilio-costal system only in a lateral part of the cranial portion of the longissimus and the splenius, or better, the spino-transversalis system. A new systematology and nomenclature of the dorsal muscles is given in a comparative table that will be given to any specially interested in the subject.

Prostate, Atrophy of. Pp. 1-35; in supplement, five drawings. (German Text.) M. Ishihara.

This investigation of a series of inflamed and senile prostates was carried on at the University in Vienna but unpublished on account of the war. The more important conclusions are:

1. Atrophic changes in senile cases that affect the parenchyma were atrophy and exfoliation of the epithelium resulting in apparent dilatation of the glands, then later decrease in size with obliteration of the lumen. In the stroma were atrophy and disappearance of muscle fibers.

2. Dilatation of the glands may be only apparent, by reason of epithelial atrophy; or real, from narrowing of the neck because of inflammation, compression from without, or obstruction by corpora amylacea. Muscle atrophy as a sign of senility was the commonest exciting cause of this dilatation, inflammation as a rule producing shrinking and obliteration of the glands.

3. The power of compensatory growth finds expression in the regeneration and hypertrophy of the glands to make good the senile impairment of functional power.

4. Physiological senile involution of the prostate occurs because of the atrophy of the musculature and the resulting glandular widening, this gradually developing into atrophy. This causes no change, per se, in size of the organ but hypertrophy or regeneration may co-exist.

5. The prostatic changes due to chronic inflammation are exfoliation and atrophy of the epithelium, dilatation, decrease and obliteration of the lumen in
the glands, proportionate increase of elastic tissue fibers and connective tissue, often small cell infiltration, leucocytic aggregation or occasional interstitial abscess formation.

6. In advanced prostatitis, especially in the aged, the atrophy was usually partly senile and partly inflammatory. Chronic inflammation does not cause an abnormal diminution in the size of the organ.

7. "Prostatic hypertrophy" really a new growth arising in the center of some portion of the lobes of the prostate. The peripheral portions were atrophic from pressure.


The authors undertook to produce the disease experimentally. A rat was caught and induced to bite the leg of a marmot. The area about the injury became greatly inflamed, the regional lymph glands enlarged and there was high fever. The animal was killed just before it would have died of the infection, and blood taken from the kidney contained spirochaetes. In the other kidney, stained by Levaditi's method, they were also demonstrated. The blood of this animal injected into another marmot caused similar symptoms and death. The same organisms were isolated from the kidney and heart blood of this animal also. The spirochaete was described as being composed of four to five short turns, pointed at both ends, slowly moving and stainable with ordinary stains. The assumption is evidently made that the bite of any rat can cause the disease, at least the one used was not stated to be suffering from any demonstrable disease.


This drug has been widely used throughout Japan and the first reports were very favorable, but the reaction has begun and conservative papers are now appearing in the literature. The author reviews a series of cases outlining five criteria by which he judges his results.

1. Fever. A reaction of longer or shorter duration followed a large number of the injections.
2. Sputum. This was reduced in quantity but cough was not specially altered.
3. Bacilli in the Sputum. More often positive after injections than before.
4. Body weight. Eighteen out of twenty-four patients had an increase during treatment, although there was a temporary decrease on the fourth day after the first injection.
5. Physical Findings in the Chest. An increase of the "catarrh" usually followed the first or second injections, which disappeared within a couple of days.

As to the dosage he followed the scheme recommended by Dr. Tanaka who advised injections at intervals of a week or ten days as follows:

First Method. 5cc., 5cc., 5cc., 5cc., 6cc., (if no serious symptoms) 5cc.
Second Method. 5cc., 5cc., 5cc., 5cc., 4cc., 4cc., 3.5cc.
Third Method. 5cc., 5cc., 5cc., 5cc., 2.5cc., 2.5cc., 2.5cc.

The decision to increase or decrease the size of the dose was based upon a consideration of the body weight and any favorable or unfavorable symptom that might be present. Absolute rest was insisted upon for three days after each injection. There were no accidents during treatment but occasionally such symptoms intervened as catarrh, hemorrhage, fever, and increased coughing. His series was in accord with that of Dr. Koga, the inventor of the drug, who reported twenty-three cases cured, twenty-two improved, seven unchanged, and three dead. The author does not state the degree of severity of the disease in his cases but casual remarks lead one to think they were not in the incipient stage. The general impression gained from the paper is that of similarity to the effects of too large doses of tuberculin.
Two typhoid carriers were reported cured by sodium salicylate and salicylic acid internally and injections of adurole (possibly asurol, a preparation containing mercury and sodium amido-oxybutyrate).

Five carriers of paratyphoid B received creosote, salol, and salicylic acid internally, chloroform enemas and adurole injections into the buttocks. Vaccines were also used in all cases, hence there is some doubt as to what really cured them. The author seemed to think the adurole was the effective agent but fails to mention doses, intervals, etc. Its chemical structure is represented to be

\[
\text{OH} \quad \text{CH} \\
\text{C}_6\text{H}_3\text{COO Na} \quad \text{NH}_2\text{CH}_2\text{C-OH} \\
\text{Hg OH} \quad \text{COOH}
\]

This substance, similar to cyanokuprol, is described as a combination of two parts of KCN and one part of copper cyanurate (cyaniuric acid, C$_3$N$_3$O$_3$H$_3$. a polymere of cyanic acid). The so-called "Kupfercyanüracyankali" occurs in small white acicular crystals, soluble in water and alcohol. The lethal dose for dogs is given as five mg. per kg. of body weight. The author injected his leprosy patients about every ten days with a .1-.1 per cent solution in doses of .25-.3 mg. per kg. of body weight. A summary of the condition fifty cases after from one to three injections is as follows:-

Decrease or disappearance of nodules ... ... ... ... 17 cases.
Dessication, cicatrization or healing of ulcers ... ... ... ... 2 ...
Improvement in general appearance ... ... ... ... 2 ...
Progressive enlargement or increase in nodules ... ... ... ... 4 ...
No change in symptons ... ... ... ... ... 11 ...

The treatment was continued for from six months to a year with what were said to be many striking results. No final summary is given but the lesions were said to heal with much scar formation, the areas decolorized slowly but completely, disturbances in sensation were ultimately restored and the thickened nerves became normal again. Lost hair was even said to have been renewed in some cases. The histological changes that took place in the shrunken nodules after several injections included caseated areas in whose periphery were giant cells. The lepra bacilli were here and there in small bunches, much decreased in actual numbers, and commonly degenerated into granules, or diffusely and homogeneously swollen.

The use of this drug in tuberculosis in animals gave complete protection when injected simultaneously with a large dose of a bacillary emulsion, and definitely prolonged the life of previously infected animals. The tubercles were surrounded by thick connective tissue capsules which sent numerous fibers into the interior. Numerous lymph channels were discernible in this connective tissue and this was considered as a sign of the resorption of the nodule. The
bacilli were for the most part in the epithelioid cells and their form could not be well distinguished. The surface of the liver of these animals had been completely covered with small T. B. foci until cured by the injection of this drug producing a diffuse granulation resembling Læmee's cirrhosis. Scar tissue contraction of numerous disseminated tuberculous foci had produced a finely granular appearance.

In the treatment of fifty-one cases of pulmonary tuberculosis the results after from one to four injections were as follows:

<table>
<thead>
<tr>
<th>Result</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much improved</td>
<td>5</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>19</td>
</tr>
<tr>
<td>Slightly</td>
<td>9</td>
</tr>
<tr>
<td>Not</td>
<td>6</td>
</tr>
<tr>
<td>Uncertain</td>
<td>11</td>
</tr>
<tr>
<td>Worse</td>
<td>1</td>
</tr>
</tbody>
</table>

Of these cases, fifteen were in the acute catarrhal stage, twenty-eight were infiltrated, and eight had cavities. A definite negative phase followed the injections, the symptoms of which disappeared within a week.


The author used Bang's method devised for the determination of the sugar content of serum with slight modifications, but both are too complicated for clinical use. His results are, however, worth recording. The normal sugar content in children ranged from .043-.077 gms. with an average of several determinations of .06 gms. It was increased in the following diseases, purulent meningitis .07, T. B. meningitis .08. The amount was reduced in pertussis, meningitis, rickets and hereditary syphilis .05 gms, occasionally in enteritis and alimentary intoxication, and commonly in serous meningitis, especially the later stages. In dyspepsia, infantile beriberi and "ekiri" (a native form of dysentery) the amount was normal.


In this article the author is concerned especially with the relation of the character of the food to the allantoin excretion. In the preliminary tests he found that the allantoin in the urine decomposed spontaneously to the extent of twenty-six per cent in thirty-five days when the reaction was acid and the temperature low, even in the absence of bacteria, hence he insists that the allantoin in metabolism experiments must be examined as soon as possible.

In the chief investigation the author compared the amount of the allantoin excreted in the urine after feeding different purin-allantoin free foods and determined that allantoin in the urine was less on a turnip diet than on oats, and that it remained constant on a prolonged diet of oats while it steadily decreased on the turnip diet. After an accurate analysis of the results on the diet of turnips the author came to the conclusion that the excretion of the allantoin in the urine, independent of the purine of the food, was influenced by the mineral content, since the mineral salts, especially calcium, influenced the purine metabolism by depressing it. Furthermore, the author exposed animals to cold and examined whether the allantoin excretion in the urine was increased through chilling. No special changes were noted. He considers it established that the allantoin metabolism has no relation to the chemistry of heat regulation.

In the titration he recommends the use of nitric acid instead of sulphuric acid.

This drug has no such specific effect upon leprosy as salvarsan has in syphilis. But it is undoubtedly able to change many extensive and serious conditions into mild, lighter ones, and this is especially marked after the first injection. It remains to be seen whether these modified cases will return again and whether further experience will improve the method of administration. It may be necessary to use chaulmoogra oil simultaneously.

Yokosuka, A certain Bacterium isolated from Antiparatyphosus, a Serum prepared from Rabbits, Pp. 464-484. Watakuclii.

This organism was first discovered in 1915 in Yokosuka, a Japanese naval base, and has been known locally by that name. The reviewer has been unable to discover that an international name has been given it so describes all the biological details available.

Morphological characteristics: Short rod without spores or branching characteristics, slight motility, i.e., more than B. Coli but less than typhoid or paratyphoid, stains readily with the ordinary stains but is Gram negative.

Cultural characteristics. Pellicle formed on broth in three days, coagulates litmus milk in two to three days changing the color to a brick red, grows well on potato resembling the Paratyphosus B., gas produced in glucose media, produces indol, liquefies gelatin in two to three days producing a liquefaction area likened to a grape leaf, Deep red colony on Endo's medium, and thin flat colonies on agar in eighteen hours. In 1.5 per cent glucose broth in twenty-four hours the amount of gas formed was

<table>
<thead>
<tr>
<th>Yokosuka</th>
<th>Paratyphoid A</th>
<th>B.</th>
<th>B. coli.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 cc.</td>
<td>1.5 cc.</td>
<td>5 cc.</td>
<td>8.5 cc.</td>
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</table>

Immunological characteristics. Non-pathogenic for mice, but 1 mg. in the ear of a rabbit was fatal. Has antigenic powers producing the same group of agglutinins as the paratyphosus but is unable to remove its specific antibodies. It evidently belongs to the colon group but its strong agglutinative power for the paratyphoid A. antibodies makes a differential serological diagnosis difficult without group absorption.


Bacilli were found on the chop sticks used by a T. B. patient. Systematic examination of the sputum on the streets showed the bacilli in 5.8 per cent in Tokyo and 2.3 per cent in Osaka (both large cities of more than a million inhabitants).


The disease begins with a diarrhea in which three to five fermented stools containing green mucus are passed per day. The face becomes gradually paler, vomiting follows nearly every feeding and after seven or eight days, contraction
of the neck begins. The child becomes stupid, the eyes roll upward occasionally, and the fontanelles are bulged. On puncture the cerebro-spinal fluid is usually clear. Most of the cases are in the summer among teething children and the prognosis is very bad. Mental symptoms or disturbances of the eye or ear may persist in those cases that recover as long as six months to one year. The author gives the brain findings in two autopsies noting fullness of vessels of the membranes, edema of choroid, and slight cloudiness of the region about the optic chiasma. There were no hemorrhages in the ventricles.

(43) MENINGISMUS (?) Hemolytic power of the Cerebro-spinal Fluid, Serum and Urine, in Cases of. Also Resistance of the Red Cells of these patients against Hemolysis as compared with the normal. Pp. 10-20. Kawamura.

This disease was described thirty-four years ago by Drs. Hirota and Ito. There have been a number of theories advanced as to its nature and etiology, chiefly concerned with the question as to whether it was a true meningitis or not. The idea of it being a benign form of tuberculous meningitis has been raised. Others view it as a toxic phenomenon arising from bacterial action in an intestinal intoxication, while the progressive secondary type of anemia is emphasized by others. Certain cells containing fatty bodies have been described in the arachnoid and given prominence accordingly.

The purpose of the tests herein described has been to demonstrate the presence of a toxin in those body fluids as indicated by the increased hemolytic power, and also to see whether the patient's blood cells were any more susceptible than normal. Spinal fluid from puncture, serum from vesicles, and urine drawn by catheter, were separately mixed with eighty-five per cent saline to dilutions of 1-2, 1-5, 1-10, and 1-20. A five per cent washed suspension of normal human red cells was made and added in equal volume to the various dilutions in sterile tubes. These were well shaken, kept in the ice box sixteen to eighteen hours, and examined for hemolysis.

1. Cerebro-spinal fluid. The color of the solutions was very varied; some were colorless, some were like the light of a "firefly" and others pale yellow. Only one was hemolyzed and this power was maintained up to a dilution of one to eighty. Some contained fibrin and others did not. Twenty-three were transparent, five slightly cloudy, and three were turbid.

2. Blood serum. Twenty-four were negative and seven positive. Of the latter one hemolyzed at a dilution of one to two, one at one to five, one at one to twenty, and two up to one to eighty.

3. Urine. Eighteen were negative and thirteen positive. As to the dilution four were at one to two, two at one to five, three at one to ten, two at one to twenty, one at one to forty, and one at one to eighty.

Control. The normal cells withstood a saline solution as low as .42-.48 per cent.

Conclusion. The author believes that these results indicate the presence of some poisonous substance in the serum and urine of some of these cases of meningismus. He was unable to correlate the positive cases with any special degree of severity of the disease, termination, or prominence of any symptom.

Supplementary problem. To determine whether the supposed toxic substance had any deleterious effect upon the patient's own corpuscles, he made emulsions from eighteen patients and sixty-nine healthy teething children of similar ages. The limit of resistance to hemolysis in the various strengths of saline solution are tabulated as follows:—
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<table>
<thead>
<tr>
<th>Per cent Saline solution</th>
<th>Patients</th>
<th>Teething children</th>
</tr>
</thead>
<tbody>
<tr>
<td>.42 ...</td>
<td>...</td>
<td>3</td>
</tr>
<tr>
<td>.44 ...</td>
<td>...</td>
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<td>.48 ...</td>
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</tbody>
</table>

average .463%  average .469%

Apparently there was no special change in the patient's red cells as indicated by the above test.


While studying the diazo reaction the author found that the addition of an oxidizing agent to a diazo-positive urine produced an intensification of the normal yellow color, and he wondered whether the progenitor of the urochrome could be connected with the production of the positive test. The same he found to be true in diazo-positive urines in other diseases. Weiss had noted the same thing in 1910 when he added a few drops of 1 per cent K\textsubscript{2}MnO\textsubscript{4}, and considered this a reaction of value. In this investigation the author has considered this latter test, which he designates the "urochromogen" as distinct from the diazo, as a possible means of diagnosis in certain cases.

Method of performing the test. He diluted a small portion of urine with three volumes of water. One half was set aside for a color control, and three drops of 1:1000 K\textsubscript{2}MnO\textsubscript{4} added to the ether. The test was positive the color became much deeper.

Results. Both tests were positive in about ninety per cent of cases of measles. In seventy-five per cent the urochromogen test was positive by the time the eruption had appeared on the face and chest, and in nearly every case it preceded the diazo. When there were only one or two spots on the back of the ears then both tests were negative. The diazo remained positive for about ten days, but the urochromogen test was irregular depending more upon the condition of the patient. Obviously neither is of much value for diagnosis under ordinary conditions.

Tokyo Igakkwai Zasshi
January 5, 1916.


By the use of inunctions of tar on the normal and scarified ears of rabbits, and the repeated injections of scarlet-red oil and other forms of counter irritation, the authors sought to produce typical carcinomata. The clear cuts show the formation of undoubted tumors, but there is no record of metastases and the masses showed retrogression when the irritant was discontinued. These heteroplastic growths evidently did not lead to a fatal termination.


"Tuba" is the Malay name of a plant known botanically as Derris elliptica, Benth., and is commonly used by the natives of the islands of East India for the killing of fish. It was examined by Greishoff in 1890, who found an active principle which he called "Derrid," but was unable to obtain it in the pure state. The author examined a sample from Borneo, and from an ethereal extract of the root isolated a different substance which he calls "Tubatoxin." Tubatoxin obtained from an alcoholic solution is in pure white crystals, variable in shape but
mostly hexagonal or acicular. Its formula was calculated to be C_{18}H_{18}O_{5}, and its melting point 163.5\,^\circ\,C. It is not hygroscopic; when heated on platinum foil it burns with a peculiar odor but leaves no ash. It is soluble in chloroform, benzol, olive oil, ether, absolute alcohol, methyl alcohol, amyl alcohol, glacial acetic acid, acetone, toluol, glycerine and petroleum ether, but is insoluble in cold water, weak acids, and alkalies. It will reduce an ammoniacal solution of silver nitrate and an alkaline solution of copper sulphate, is not affected in the cold by strong alkalies, but is destroyed by strong sulphuric and nitric acids.

If one or two drops of fuming nitric acid are added to a solution of tubactorix in glacial acetic acid and to this combination water be added, a yellow color will be produced. If this combination be put into dilute caustic soda a colored ring will appear at the line of contact which is green above and reddish-brown below. This reaction is very delicate and demonstrates the presence of 0.001 gm. of tubactorix.

The symptoms produced in animals (fish, frog, rat, rabbit, and dog) were general motor paralysis with dyspnoea of central origin. Blood pressure was first raised, then markedly depressed, and pulsation of the heart gradually ceased. The smallest lethal dose for the rabbit was found to be 0.0009 gm. per kg. of body weight when injected intravenously, but injected subcutaneously it was absorbed with difficulty.


On the basis of the findings in 500 autopsies and of 103 appendices removed for disease, the author studied the incidence of oxyurus infection in Berlin and sought to trace its relation to the pathology of the appendix. At the autopsies only forty-four appendices were found infected, and in twenty-nine of these the worms were confined to the lumen and were unattached. In six others *Trichocephalus* was found free in the lumen, and in five there were segments of tape worms. The presence of *Oxyurus* was, with very few exceptions, of no pathological significance. Those burrowing in the walls, by making small lesions in the mucosa, may allow bacteria to enter and thus be important. This type of lesion is designated "Appendicopathia oxyurica traumatica," and is usually characterized histologically by minute hemorrhages in the tissue injured. A form in which the symptoms of an appendix lesion were present, but without inflammation, is called "Appendicitis oxyurica," and in these cases there is uncertainty as to the rôle played by the worms which were occasionally seen in the walls. No mention is made on the clinical side as to the presence or absence of leukocytes, etc., but the author is firm in his conviction that *Oxyurus* in these cases is of little significance, and contends that the fissures and clefts in the tissues are largely artefacts inasmuch as they are found most frequently in the lymphoid and other tissues where the worms are not found.

A point of differentiation between *Oxyurus* and *Trichocephalus* as seen in the sections is that the wall of the latter is composed of two layers, the inner one stained red with the eosin and the outer one colorless, whereas *Oxyurus* has only the colored inner wall. The eggs of the two species are not so easily differentiated when they are cut diagonally or transversely as the plugs at the ends of the whip-worm egg are then not apparent. The yolk of the egg of *Oxyurus* stained intensely with the hemalum and there was a space between it and the shell; in *Trichocephalus* both the staining and the space were absent.

Hifu Kwa, Hitsu Nyo Kwa Zasshi
February, 1916.


Dr. Kinchi has previously described a method of using dried placenta powder in the testing of the urine of pregnancy and the author has been trying the method out in other conditions. It was positive in all cases of pregnancy but also in various kinds of skin diseases such as eczema, lupus, and scabies. It was also positive in one man. This powder seems to be marketed under the name of "Ninseline."

Tokyo Igaku Kai Zasshi
March 20, 1916.


The author records this condition as having been found in fifteen out of a series of 125 autopsies performed by him on Japanese. In only two of these was the pigmentation evident macroscopically. Age seems to be an important factor in that only two cases were in persons under the age of thirty, but as the two cases of intense pigmentation above noted were not in the older persons it is evident that age alone is not the determining factor. Cancer was the cause of death in six cases, melanoma in one, tuberculosis in two, and some died from other diseases in which no obvious connection was noted. Constipation had been present in twelve of the cases in earlier years. From the details of all the cases it was evident that the pigment occurred more commonly in cachectic and constipated individuals during the later years of life but occasionally was found in the young in the absence of either of these conditions.

Characteristics of the Pigment. (1) Macroscopic findings in the bowel. The pigmentation was commonly limited to the colon. Above, it was sharply differentiated from the non-pigmented ileum, and below it ended in the usually pigment-free rectum. In one case the rectum was pigmented and in another the descending colon was free. The appendix was sometimes pigmented but the regional lymph glands were free. The pigmented mucosa was colored brown to dark brown, divided into small, irregular shaped areas in which the follicles were distinguished as colorless spots. This arrangement was characteristic of the upper portion but was often lacking in the lower.

(2) Microscopic appearance. The pigment was granular, yellow to yellowish-brown in color, definitely limited to the tunica propria and usually intracellular. It was rarely demonstrable in the mucosa of the ileum or the submucosa of the colon. As to its zonal distribution it was found most in the inner portion, some in the middle and but rarely in the outer.

Microchemical Reactions. (1) Iron reaction, negative.
(2) Fat and Lipoid reactions. Sudan III, Fischler, Ciaccio, Golodetz, Osmic acid, all uncolored. Nile blue, bluish-green or bright greenish-blue. Smith-Dietrich, partly positive.
(3) Solubility. Not in fat solvents. In mineral acids or alkalies, insoluble or soluble with difficulty. In fuming nitric acid and in hot solution of caustic potash, the color was completely discharged. Heated in an alcoholic solution of KOH it was rather easily soluble. In Aqua regia it was for the most part soluble.
(4) Reduction of AgNO₃, weakly positive.
(5) Decolorized in Chlorine gas and by H₂O₂. The pigment bodies decolorized with pyrozone were stained greenish-blue with Nile blue.
(6) With the blue aniline dyes such as thionin, methylene blue, and polychrome methylene blue, the pigment bodies were stained blue. With neutral red they were tinted pale red, but were unstained by hematoxylin combinations.
Japanese Medical Literature.

(7) Schultz's oxypase reaction, negative.

Conclusions. On the basis of the above findings the author concluded that the pigment was not a hemoglobin derivative, nor related to fats or lipoids, but resembled the melanins in some of the more fundamental features. There were some differences, however, in staining reactions, etc., so as to warrant it being classed separately. It resembled the pigment found in ochronosis more closely than any other described form.

Pigment-bearing Cells. Histologically these were large, round, elongated, or spindle-shaped. The nuclei were small, round, and rich in chromatin, but at times somewhat vesicular and poor in chromatin. The pigment granules were always in the protoplasm, never in the nucleus, and were associated with some fat and lipoid bodies. In the mildest cases the bodies were clustered closely about the nucleus, but as they increased in abundance and size they finally filled up the entire cell and obscured the nucleus. The identity of the pigment-bearing cell was not definitely determined, whether a fibroblast as claimed by Pick, or a wandering cell according to Henschen, but the author was inclined to correlate it with the histiocytote of Aschoff and Kiyono.


In order to determine whether the phosphorus compound called nucleon, isolated first by Siegfried and then by Wittmaack was a real substance or not, the author followed the methods employed by the latter and after certain additional investigation summarized the work as follows:—

(1) The separation methods employed were insufficient in the following points: The removal of the casein was incomplete. The extraction of phosphates through the addition of calcium chloride was likewise insufficient, with the result that the remaining phosphates were precipitated as iron phosphate on the addition of ferric chloride.

(2) If the so-called nucleon were really a chemical entity then the amount of nitrogen and phosphorus it contains must always be the same, whereas the amount of these bound in chemical combination varied with the amount of ferric chloride added.

(3) The nitrogen and phosphorus content of the albuminous compounds removed from milk by ether extraction was constant as was also that in the separated precipitate from this filtrate.

(4) The total amount of phosphorus which was contained in the compounds separated by ether extraction, or found in the iron combinations from the filtrate, corresponds closely to the amount of phosphorus which was obtained direct from the milk without ether extraction by the addition of ferric chloride as the so-called nucleon. From this it is certain that the nucleon was in reality only a separated portion of the protein content of the milk.


The roots of Cnidium officinale are much used by native practitioners of China, Korea, and Japan for various nervous diseases, especially those of the head and brain and also for some female disorders. The writer's is supposed to be the first scientific investigation of the plant.

The chief ingredient of extracts of this drug is a volatile oil, named by the author, oil of cnidium, which is present to the extent of about 0.8% by weight. It is yellowish-brown in color, has a peculiar odor and bitter taste, and a specific gravity of about 1.030-1.040. It is soluble in alcohol but not in water and is levulorotary. Further investigation of this oily substance yielded a free, unsaturated acid, with the formula of \(C_{12}H_{19}O_3\) and an alcohol whose composition was found to be \(C_{10}H_{18}O_3\). A lactone (?) was also found with the formula of \(C_{12}H_{18}O_2\).
The chief action of the oil is that of raising the blood pressure by stimulating the vaso-constrictors. Its action on the central nervous system is stimulating, and its use increases the reflexes by reason of spinal irritation. It apparently has no effect upon the kidneys but in large doses the acid is able to produce hemolysis.

Taiwan Igaku Kai Zasshi
(Journal of the Formosa Medical Society) No. 161.
March 28, 1916.


The blood of two cases of malaria, of the benign and of the subtertian type, were cultivated according to the method of Bass and Johns, and Ziemann and Thomson. The malignant type was easily cultivated, but the benign tertian failed to grow, supposedly because the patients had been treated in the attack with quinine. In the cultures many of the red cells contained as many as three to four parasites each. The crescents were seen to give rise to sexual forms which showed great activity. The merozoites were found to live a long time outside the red cells but only when the leucocytes had been previously removed. The authors used a special pipette for incubation. This had a cotton plug and rubber bulb at one end, was bent at right angles near the end and drawn out to a fine point which was closed in the flame after being filled.


In 1915 there was a veritable epidemic of dengue in which 72% of the patients had the plasmodia of malaria in the blood. Hundreds were attacked and many died. The subtertian type was the most common, benign tertian came next, and there were a few cases of the quartan type. Anopheles sinensis was said to be the chief carrier.

Other mosquito carriers reported from there were Myzorhynchus sinensis, Nyssomyzomyia rossi, Nyssomyzomyia ludlowi and Myjomyia listonia. The names of other forms that occur there are Siegomyia fasciata (S. calopus, Aedes calopus), S. scutellaris, Culex fatigans, C. sitiens, C. concolor and Desvoidea obturans.

Hifu Kwa, Hitu Nyo Kwa Zasshi
March 30, 1916.


This article contains much the same information as found in the paper published by the authors in the Journal Exp. Medicine xxiii, No. 4, 1916, pp. 557-562, pl. 88-89, but a few more facts are added. Although best stained by the Giemsa method, the spirochetes can be also fairly well stained by gentian violet, 0.7%, aniline gentian violet, 0.7%, carbol fuchsin, 0.1%, fuchsin, 0.1%, methylene blue, Loeffler's methylene blue, safranin and Orange G, solutions. In the gentian violet preparations the spirochetes appear violet, or a little reddish violet, and in most cases the finer waves that are so difficultly seen in the Giemsa stains are easily seen. In addition to the stained methods they can be demonstrated by the India ink, collargol and their gelatin-hematoxylin methods in which they appear even to the finest detail as bright objects against the dark background. They decolorize with Gram's method. Division is probably both by cross and longitudinal separation. The illustrations are intended to show the latter method of multiplication. In making the gelatin-hematoxylin preparations a small amount
of a gelatin culture is smeared thinly by means of two cover-glasses and allowed to
dry. Vapor of osmic acid is allowed to act on it for five seconds and it is again
dried. After fixation in alcohol or alcoholic ether it is stained with Hansen's
hematoxylin for 5-10 minutes and immersed in water until differentiated. It is
then dried and sealed with balsam. The gelatin alone stains reddish-blue leaving
the organism as a clear line of varying shape.

Spirocheta icterohemorrhagiae. Showing longitudinal division.

(56) XERODERMA PIGMENTOSUM, Tumors secondary to. Pp. 216-243. K.
Nakagawa. Four pl. and five pictures in the text.

As complications of this disease there are here recorded five squamous
epitheliomas (one a nevocarcinoma of Unna), one cutaneous horn, one fibroma,
and one melanosarcoma. The author is convinced that the sun's rays are the
determining factor in stimulating to further aberrant growth a skin that is highly
sensitive and perhaps predisposed. The number of the cases occurring on the face
or other exposed portions, chiefly in males, helps to bear out this idea. The
melanosis is believed to be reactive in character as a protection against these rays.

S. Ishihara.

This is the trade name for a solution of 10% iodine and 15% camphor in cod
liver oil, and its injection into the urethra is highly recommended as a cure for the
blennorrhoea.

(58) LEPROSY, HISTORICAL. Pp. 75-82. K. Dohi.

Fowler's solution in daily doses of 1-1.5 cc. was reported as having proven
very effective in five cases.

Saikin Gaku Zashi
(Journal of Bacteriology) No. 246.
April 1, 1916.
The China Medical Journal.


The author studied the cases in the villages around Shushin adjoining the east coast of Japan, where are found various tropical diseases especially those of parasitic origin. In all, 1,077 persons were examined and forty-two were found infected with Schistosomum jap., all but three of whom were farmers. Only twenty-two of these realized that they were not healthy. Ten patients had enlarged livers and twelve tenderness on pressure. Most of the patients remembered having had an itchy eruption on the legs about a year previous, but recalled no constitutional symptoms.

Tokyo Igakkwai Zaschi

April 5, 1916.

(64) Tubercle Bacilli, Restraining action of various metallic salts, dyes and other agents upon cultures of. Pp. 365-399. S. Takenaka.


The results of the research established the following facts and gave the author a new conception of the meaning of these pigment bodies.

(1) The glandular epithelium of the prostate contains pigment bodies after puberty under physiological conditions. As a rule they are in the basal portion of the cells near the nucleus. Their number is different in the different glands of the same prostate and indeed in different parts of the same gland. The number and size of the granules correspond to the age of the person.

(2) The granules are fine or coarse, irregular angular masses, which have a peculiar yellow or yellowish-brown color. They are not doubly refractive.

(3) They are unchanged by acids and alkalies and soluble with difficulty in fat solvents. With bleaching solutions the color is gradually discharged. They are colored orange red by Sudan III and scarlet red, purplish with Nile blue, and brownish-black with osmic acid. They stain according to the methods of Ciaccio, Smith-Dietrich, and Fischler.

(4) The granules probably contain phosphatids, cerebrosides, cholesterin-fatty mixtures, modified fatty acids and soaps, and some coloring matter. They are classed as lipoid pigments.

(5) Their appearance in the prostatic secretion means the destruction of the granule-bearing epithelium and granular epithelium with consequent liberation of the granules, and they are not an integral part of that fluid.

(6) The pigment granules in the epithelial cells of the ejaculatory duct consist of degeneration pigments which has the same significance as that in the seminal vesicles. Its distribution in the epithelial cells is not regular, still it occurs more abundantly in the glands of the ejaculatory duct than in the mucous membrane above. The number and size of these granules correspond well with the age.

(7) In the prostatic musculature are to be found physiologically pigmented smooth muscle fibers in more or less abundance. The pigment bodies of these fibers belong probably to the class of lipoids and are of two sorts; one, in the form of very fine brown granules, gives a faint fat reaction; the other has a weak reaction for iron and a decided one for lipid.

The subjects dealt with in these papers are very important as nervous and mental disorders are undoubtedly becoming more common owing to the strain of modern civilisation and the perpetuation of degenerate stocks. Apart from the cases of insanity due to ascertainable physical causes, there are the innumerable cases of hysteria, neurasthenia, weak-mindedness, moral imbecility, and other mental ailments, many of them of obscure origin and strange manifestations. These cases are now attracting very much attention, and psychoanalysis has become a distinct branch of medical science.

It seems to be generally agreed that the source of most of these disorders lies in the subliminal consciousness, or the "Unconscious" as it is here termed, that strange region of the mind which contains all the memories of the past, the history of all previous conflicts and struggles, and the effects of baffled desires and of the restraint of the natural impulses of the lower nature. Moreover, to quote from William James, "it harbors the springs of all our obscurely motivated passions, impulses, likes, dislikes, and prejudices. Our intuitions, hypotheses, fancies, superstitious, persuasions, convictious, and in general all our non-rational operations come from it. It is the source of all our dreams and apparently they may return to it. In its arises whatever mystical experiences we may have and our automatisms, sensory or motor; our life in hypnotic and hypnoid conditions; our delusions, fixed ideas, and hysterical accidents, if we are hysterical subjects."

This region has, as it were, an existence of its own more or less independent of the primary consciousness, and it should be one of the objects of life to bring the two into perfect harmony. When the relation between them is seriously disturbed and the primary consciousness loses full control, then the unconsciousness manifests itself in abnormal mental conditions. In such cases the problem is to discover the painful but inactive memory, the baffled desire, or whatever it may be that is disturbing the mental equilibrium, bring it to the light and so remove its baneful influence. The patient himself may be ignorant of it, as it may be something connected with the days of early child-
hood and so have been long forgotten. Infancy and childhood, in the opinion of the psychoanalysts, is very far indeed from being a state of innocence; on the contrary, from their point of view, in that period we are all little wretches quite justifying the theological doctrine of infant depravity. For the neurotic is said to be entirely dependent upon his infantile past; and all his troubles in later life, his moral conflicts and deficiencies, seem to be derived from the powerful influences of that period.

The minor methods of psychoanalysis are to encourage the patient to talk as freely as possible about himself, and certain association tests. The analysis of dreams, however, is the principal method. According to Freud and his school, the dream is, in its essence, a symbolic veil for repressed desires, generally sexual. For instance, a young man dreams as follows: *I am standing in a strange garden, and pluck an apple from a tree. I look about cautiously, to make sure no one sees me.* This dream reveals that he once stole some pears, was guilty of an erotic misdemeanour in childhood for which his father punished him, that he was in a state of revolt against the Biblical story of the Garden of Eden, and that a short time before his dream he was having a questionable love affair with a housemaid.

But Jung, the author of the book under review, does not go the whole way with Freud. He contends that when confronted by difficult tasks in life, the dream, to which Freud would give a sexual interpretation, may represent a psychological effort of the consciousness to overcome these difficulties, and that "biological justice, which is inexorable, sometimes compels the human being to atone in his dreams for the duties which he has neglected in real life." Much of this book is taken up with the explication and defense of this theory.

The author holds the belief—which if true will do much to lighten the distress felt for the insane—that in insanity pathological images dominate the interests of the patient so completely, because they are simply derivatives of the most important questions that used to occupy the person when normal—what in insanity is now an incomprehensible maze of symptoms, used to be fields of vital interest to the former personality. Consequently, the mental life of the insane is not one of utter impoverishment or distress. "Every human being has within himself that restless creative phantasy which is ever engaged in assuaging the harshness of reality. Whoever gives himself carefully and unsparingly to self-observation will realize that there dwells within him something which would gladly hide and cover up all that is difficult and questionable in life, and thus procure an easy and free path.
Insanity grants the upper hand to this something. When once it is uppermost, reality is more or less quickly driven out. It becomes a distant dream, and the dream which enchains the patient wholly or in part, and often for life, has now the attributes of reality. We normal persons who have to do entirely with reality, see only the products of disordered fancies, but not the wealth of that side of the mind which is turned away from us. This life is far removed from that mental poverty which the prevailing theories were compelled to accept."

The work is very instructive but much more remains to be done. Nothing is said of the latah of the Malays, the ikota of the Samoyads, demoniacal possession, lycanthropy and the kindred psychopathies of primitive peoples, which cannot be wholly ascribed to baffled sexual desires nor even to efforts to overcome the difficulties of daily life. There are other corroding passions in human life besides the sexual. Then to discover the inimical influence in the Unconsciousness of a neurasthenic does not necessarily imply that it is or will be conquered, as sexual irregularities, for instance, may be the consequence, not the cause, of the mental and nervous disorder. Despite all criticism, however, the work is very valuable, especially for those who have neurasthenics, hysterics, and other queer people in their care, and parents will find in it helpful hints on the early training of children and of the best way for dealing with little minds which are too inquisitive. Further, psychoanalysis is proving of great service in the present European war in dealing with the mental effects of shell-shock. But we are learning that it is not always wise to revive the memory of painful or horrifying events.


Since the last edition of this work was issued there has been considerable discussion among orthopedists concerning the treatment of scoliosis by forcible correction, and much unfavorable criticism of the method has been published. The author in this edition gives the results of his own personal experience and states what he has himself accomplished by forcible correction. He has also rearranged certain parts of the book in order to present with greater clearness certain phases of this complicated affection and has rewritten a large part of the section on treatment.
In Western lands scoliosis is found more often in girls than in boys. It would be interesting to know what the proportion is in China, and if the binding of the feet of Chinese girls, which interferes with the natural gait and must also affect the movements of the spine, favors the development of this deformity or not.

There is a valuable chapter on the relation of scoliosis to school-life and the cautious conclusion is reached that apparently if one takes into account all the grades of scoliosis, functional and structural, there is a tendency to increase during school years, but there is apparently no good evidence that moderate and severe structural scolioses increase during school life or are directly caused by it.

The various forms of treatment, including the gymnastic, are well described and the illustrations are numerous. The work is indispensable to all surgeons interested in orthopedics, and should be studied by those of the laity in charge of the physical well-being of the children in our educational institutions.


It is stated that the object in view in publishing this new edition of “Gould’s Practitioner’s Medical Dictionary” was to provide a modern dictionary for physicians and medical students that should be up-to-date; contain all the words that are needed; be issued in a form convenient to handle and to be published at a low price. In our judgment all these ends have been accomplished. Among the admirable medical dictionaries now published, those compiled by Gould always receive honorable mention and have a deservedly large sale. More than one-third of a million copies are in the hands of the English-speaking practitioners in the world. About 70,000 terms are defined in this edition.

In the preface there is the following interesting statement: ‘Among many, one illustration of the unexpected reach of far-off influence may be permitted:—In the English-Chinese Lexicon of Medical Terms, compiled by Philip B. Consland, M.B., C.M., (Edin.), the valorous, philanthropic, and learned editor, in his preface says: ‘It is largely based on Gould’s Medical Dictionary and the Nomenclature of the Royal College of Physicians of England, etc.’” As missionary physicians do not always receive superabundant praise
it does one good to see Dr. Cousland, and by implication all his colleagues, described as valorous, philanthropic and learned. In spite of old Simon Browne, who left it on record that he "took to an employment which did not require a soul and so became a dictionary maker," we think this kindly commendation is plain proof that in these days lexicographers are endowed with and manage, perhaps with some difficulty, to preserve their souls. Browne is much more sensible when he piously adds that we should "thank God for everything, and therefore for dictionary makers."

AN INTRODUCTION TO NEUROLOGY. By C. Judson Herrick, Ph.D., Prof. of Neurology in the University of Chicago. 12mo of 360 pages. Illustrated. Cloth 7/6 net. W. B. Saunders' Company, Philadelphia and London.

Few will question the statement that the study of the nervous system as laid down in most of our text-books of anatomy and physiology is both difficult and dry for the beginner, chiefly because of the lack of correlation of the structures described with their functions. The work under review, designed as an introduction to the study of neurology, is written in the hope that it will help the student to organize his knowledge in definite functional patterns and to appreciate the significance of the nervous system as a working mechanism much earlier than is often the case.

The book is clearly and pleasantly written, well illustrated, and its value greatly enhanced by constant reference to the facts of comparative anatomy and embryology. The medical student who masters it will have made a very good beginning in neurology and will find the rest of his work on this subject prior to graduation comparatively easy.


This useful compend-condenses for the student the important facts of physiology without in any way lessening the necessity of attendance at lectures and the performance of laboratory work. In this edition much new material has been introduced, such as the physics of electric stimulation, the chemistry and physiology of the amino-acids, the galvanometric method of recording electric phenomena, the source and classification of the leucocytes, and many new facts in relation to the circulation, including electro-cardiography, venous pulse, etc. The
The China Medical Journal.

questions grouped at the end of each chapter are a most valuable feature of the book as they are sufficiently exhaustive to test thoroughly the student’s advancing knowledge of physiology.


The brilliantly successful campaigns against Malaria and Yellow Fever both in Havana and in the Isthmian Canal Zone are now well known over the whole civilized world, and have demonstrated the vitally important fact that it is possible for the white race to live and thrive in the tropics. In China, Yellow Fever has not yet appeared, but with the opening of the Panama Canal and the possibility of its finding a lodgment in Japan—it is reported that one case was discovered in Yokohama some time ago—it may arrive and become epidemic, as Stegomyia scutellaris which is closely allied to Stegomyia fasciata (now known as Aedes calopus) is present, and all the conditions are favorable to the propagation of this dreaded fever.

As malaria is very common in China this book will be particularly helpful to all those engaged directly or indirectly in warfare against it, the laity as well as the medical profession. An interesting account is given of the anti-malarial campaigns in Havana and Panama, which is followed by a description of numerous species of anopheles, their habits, breeding places, and the most effective ways for destroying this mosquito in the various stages of its existence. The work is clearly and interestingly written, and is admirably illustrated. In the Book of Proverbs, Agur, the son of Jakeh, writes that there are four things which are little upon the earth, but they are exceeding wise, the ant, the cony, the locust, and the lizard. This book will do much to convince the reader that at the least the mosquito deserves honorable mention in this connection.

The Medical Journal of Hangchow Medical College.

This Journal is edited in Chinese by the Alumni Association of the Hangchow Medical College. The issue for February, 1916, received for review, consists chiefly of translations of various medical papers. It opens with an article on Leprosy by Dr. Duncan Main. Then follows a series of articles on "The Extensive Use of Morphia in
Shanghai”; “Medical Ethics”; “Therapy of Suprarenal Gland”; “Therapy of Thyroid Gland”; “Variola”; “Phthisis”; “Radium Therapy”; “Principles in Nursing,” and other miscellaneous matters which complete the number. The conclusion one comes to, after reading these articles, is the advisability of those interested in Chinese medical literature entering into some kind of combination. There are in China only about three medical journals published in the Chinese language. As a separate entity, each may not accomplish much, but if amalgamated into one National Medical Journal, this could at once be made an enlightening and uplifting influence in all that concerns medicine and the medical profession of China.

**Nurses' Association of China.**

**OFFICERS, 1915 TO 1916.**

*President:* Miss E. Hope-Bell, Hankow.
*Vice-President:* Mrs. Bayard Lyon, Tientsin.
*Treasurer:* Miss Chisholm, Shanghai.
*General Secretary:* Miss Alice Clark, Shanghai.
*Editorial Secretary:* Miss Laura Lenhart, Shanghai.

**SUGGESTIONS FOR A COURSE ON HOME HYGIENE.**

*For the Younger Girls:*

Teach by instruction and inspection:

I. Habits of cleanliness, such as
   1. Regular bathing.
   2. Brushing of the teeth night and morning.
   3. Changing the innermost clothes frequently.
   4. Using, when eating, two pairs of chopsticks, one pair to serve oneself with from the general bowl, the other to eat with. These should be of different colors to prevent interchanging.
   5. Spitting into a spittoon, as spitting on the floor spreads consumption.

II. The advantages of exercise,
More oxygen in the blood with better bodies, and better brains because of this oxygen.
Loose clothes must be worn while exercising.
For the Older Girls:

1. Most epidemic diseases are due to germs, which, though small, can almost always be seen under the microscope, made to grow in test-tubes, and reproduced in animals and man.

2. These disease germs are spread from person to person, either directly (as in consumption, diphtheria, smallpox), or through the agency of insects, e.g., the rat-flea in plague, the mosquito in malaria, the fly in typhoid and infantile diarrhoea, the louse in relapsing fever, the bed-bug in typhus.

3. These diseases may therefore be prevented or stopped by destroying the germs, insects, rats, etc., which cause or aid in the transmission of these diseases.

4. Spitting upon the floor is a dirty and dangerous habit, for it is liable to spread lung diseases, especially the dreaded consumption. Therefore, learn to avoid spitting, for very often it is only a habit practised from childhood.

5. Smallpox is a disfiguring and often fatal disease which can be easily prevented by vaccinating the child when young with calf-lymph. When a case of smallpox occurs it should always be strictly isolated.

6. Dirty water is not good for bathing or drinking, for it may contain parasitic organisms which can produce serious diseases such as hookworm disease, anaemia, dysentery; parasitic diseases of the bowels, etc.

7. A dark, damp and dusty room attracts and breeds germs, whereas a sunny, dry and clean place kills them. Therefore, keep your quarters clean and take plenty of fresh air.

8. All public health measures require the co-operation of the authorities and local community, as infectious diseases may spread from the lowest to the highest, and vice versa. That is why rich and poor must obey sanitary laws for the benefit of the whole community.

9. The continued existence of some terrible and easily eradicated diseases in China has given her the name of 'the most insanitary nation on earth.' For our own sakes and the reputation of our country we must try to remove this stigma. These diseases are:—smallpox, leprosy, plague, typhus, etc. Most of these can be done away with in one generation if simple sanitary precautions are adopted. Many patients with disfiguring tumors, ulcers, and skin diseases can be cured by proper treatment.
For the Women:—

The women can be interested by a series of talks or an illustrated lecture along the following lines:—

1. Vaccination: All babies over six months should be vaccinated at once, and revaccinated in three or four years.

2. Ophthalmia: All babies with red eyes should be taken to a foreign doctor at once. Keep fingers away from the eyes.

3. Skin Diseases: A baby's skin should be kept clean and dry, especially in the summer. Do not take the children to dirty barber shops.

4. Food: Uncooked food is dangerous. Do not eat fruit that has been opened on the streets.

5. Sanitation: (a) Flies are dirty and carry infection to all uncovered food. This is the most frequent way of spreading dysentery, diarrhoea, cholera, and typhoid. Either screen your house or your food, or catch the flies. (b) Mosquitoes transmit malaria, therefore clean the drains and throw away all old tin cans, and use a netting over the bed at night.

6. Coughs and Colds: A person with a cough should see a doctor at once. To prevent catching cold, the windows in bedrooms should be kept open at night.

7. Contagion: Most diseases are transmitted from one person to another,—coughs, colds, red eyes, sore throat, diarrhoea, dysentery, cholera, typhus, typhoid, plague.

8. Prevention: (a) Keep the body clean,—no lice, no fleas, never touch anything dirty, wash hands immediately before eating. (b) Keep the house clean,—no rats, no bedbugs, no flies, no mosquitoes, no stale food, no stoppage of drains. (c) Keep the body strong,—fresh air, well cooked food, exercise, sufficient sleep.
Correspondence.

Correspondents are requested to write on one side of the paper only, and always to send their real names and addresses. The Journal does not hold itself responsible for the opinions or assertions of correspondents; nor can it undertake to return unused MSS.

"Some Make Themselves Eunuchs."

To the Editor, C.M.J.,

Dear Sir: Your leading article in the July issue of the Journal under the above heading, and your reference to Dr. Sircar's case of self-mutilation as "extremely rare," remind me of a similar occurrence some ten years ago when I was in private practice in Penang. In this case the patient was the head priest—a stout well-built man of 45 years of age—of the picturesque Buddhist Temple on the hill, so well known to visitors to that British colony. One night I received an urgent summons to proceed to this temple which is six miles from the town. On arrival I found the priest, whom I had known for some years, suffering from considerable bleeding from a recent wound caused by his having amputated the penis with a Chinese razor. Both testicles were still intact but partly exposed; the penis was nearly all gone and the urethra had retracted. After some difficulty the wall of the urethral canal was stitched to the adjoining tissues, and healing, though slow and hampered by difficulty in micturition, was complete at the end of five weeks. The history was peculiar. This priest had been admitted into the faith for nearly 25 years, was very popular among all classes, and mainly through his efforts the large sum of $400,000 required for the building of the beautiful temple was raised from the Straits Settlements. Among his most valuable supporters were ladies from rich families. Enemies began to spread rumours of illicit relations with his women visitors. This affected him so greatly that he decided to remove his penis. He carried out the operation himself some hours before I saw him that night, and it was the continuous bleeding which frightened his assistants into calling me. As far as I know, this priest is still in Penang as friendly and popular as ever.

Wu Lien Teh.

Nature of Korean Epidemic?

To the Editor, C.M.J.,

Dear Sir: May I ask if any of the readers of the Journal can give me any information concerning a disease, epidemic in the spring months, which simulates Acute Pernicious Beri-beri,—marked cardiac symptoms, loss of knee-jerks, etc. There has been an epidemic of this kind in this part of Korea where poor millet is the main article of diet and the ground is swampy. The symptoms generally improved on change of diet.

Yours truly,

S. H. Martin, M.B., C.M.

Kanto, Korea, June, 1916.

Urinary Calculi: Information Wanted.

To the Editor, C.M.J.,

Dear Sir: I am carrying on an investigation concerning the effect of hard water on health, with special reference to the formation of urinary calculi. There is said to be a geographical distribution in the occurrence of urinary calculi. For instance, they say that they are very common at Canton and very rare at Amoy. Some maintain that the incidence is greatest in regions with limestone soil.

If possible I would like to get some information along the following lines:
1. The prevalence of urinary calculi.
2. The mineral content of the drinking water in the same region.
3. The character of the soil.
4. The degree of pollution of the drinking water.
5. The chemical constitution of urinary calculi in that region.
6. The possibility of obtaining samples of urinary calculi for analysis.

I would be very grateful if you could furnish me with any information along any of these lines or put me in touch with any sources of information.

Very truly,

John T. Myers.

The University of Chicago,

Dep't of Hygiene and Bacteriology.
To the Editor, C. M. J.,

Dear Sir: The following history or description of the illness of a child written by the father was handed to me recently.

(This child is three years of age, he has got a sick about a month ago, and kind of his sick is by Inner Hot.

Diseases [symptoms] mentioned below:
1. Inner Hot.
2. Liver-wind is moving.
3. Large Bowel is dry.
4. Breathing is dropping to the small bowel.
5. Muscle moved before and recovered now.
6. Urine and Excrement are alright.

An egg in the small bowel dropsied down by weak "breath after all sickness recovered."

Who will venture to make the diagnosis?

Yours sincerely,

J. Lee H. Paterson.

Tsaoshim, Hupeh.

NEWS AND COMMENT.

BIRTH.

Bersst—At Hengchow, Hunan, on July 1, 1916, to Dr. and Mrs. W. L. Bersst, A.M.P. a daughter (Winifred Bromley).

Tucker—At Shanghai, July 13, 1916, to Dr. and Mrs. A. W. Tucker, American Church Mission, a daughter (Annie Cheshire).

MARRIAGE.


DEATH


A cable was recently received in Shanghai conveying the news of the death, from wounds received in France, of the above medical missionary, who had been on the staff of the Union Medical College, Peking, for some years, besides being medical officer of the Chinese Customs and to other residents in the capital.

Dr. Stenhouse was home on furlough when the war broke out, having completed a course of special study in tropical diseases, and had booked his passage to return. He cancelled the passage and immediately offered himself for war service. He had been in France a year, and, when the big push began on July 1, 1916, he was at a clearing station near the fighting line. Two months earlier his brother, Major Herbert Stenhouse, D.S.O., M.C., of the General Staff, was killed.

Dr. Stenhouse was born in India, where his father was a Major-General in the army. Educated in Switzerland, and at Cambridge University, where he took his degree, he proceeded to London Hospital for his professional training. After graduating he was for two years tutor and companion to Prince Leopold of Hattenberg. When in Egypt with the Prince he was influenced by some references to the Peking Medical College and offered his services forthwith to that institution. During the years he spent there he did great and valuable work, and was much beloved by his colleagues and the students.

He went with Dr. Wu Lien-teh to Harbin during the days of the plague, and escaped unscathed from that ordeal of ten weeks. Later, at the time of the revolution, he led a squad of his students to Hauchouf, where General Chang Hau was in power, and they were kept busy for some time in Red Cross work. During his furlough Dr. Stenhouse had joined the London Missionary Society. He leaves behind him a widow, the daughter of Dr. Hopkip Rees of the Christian Literature Society, Shanghai, and two sons, the elder of whom is only five.—N. C. Daily News.

ARRIVALS.

On June 28, 1916, Dr. Allen C. Hutcher-son, American Presbyterian Mission, South, returned from the States, and is now at his station, Kashing.
DEPARTURES.

On July 2, 1916, Miss M. A. Mackey, M.D., American Presbyterian Mission, Paotingfu, Chi.

On July 14, 1916, Dr. and Mrs. C. F. Johnson and son, American Presbyterian Mission, Tsinan, Shantung.

On July 24, 1916, Dr. Mabel Hanning-Ton, Church Missionary Society, Ning-teh, Fu.

In conformity with the missionary enterprises of other American educational institutions, the alumni and students of Johns Hopkins Medical School, Baltimore, have formed an organization to take over and develop the hospital work in a certain district in the northern part of Siam and eventually to open a medical school of the highest possible grade. The staff will consist, preferably, of graduates of the Johns Hopkins Medical School.

The Canton Medical Missionary Society is reorganizing the work of the Canton Hospital with a view to establishing it as a Union Hospital in which the preaching of the Gospel shall be incorporated with the medical work. All the Protestant missions of the province of Kwangtung are invited to cooperate.

SCARLET FEVER IN Sining, KANSU.
—This fever never leaves us. Every autumn and winter finds some children suffering, but every few years it appears among us in a more malignant form, and cuts off children in large numbers. The malignant form has been prevalent this winter and hundreds of children have died. In one village of forty families, sixty children died. It is no respecter of persons, and this year entered a little isolated missionary home and carried off two little children, a girl aged six and a boy of three.—N. C. Daily News.

ROCKEFELLER MEDICAL SCHOOLS.
—"We are convinced that the best service which the China Medical Board can render in China is the establishment of two medical schools of the highest grade possible under existing conditions, where young men and young women may be so trained in medicine as that they themselves shall become the producers and the teachers of modern medicine for China. That our largest service will not be rendered by aiding a large number of schools, or a considerable number of schools, here and there, to train men imperfectly, who themselves have had imperfect preparation for the immediate needs of China; but that the greatest service we can render, and the most permanent service we can render, is that of establishing these two schools on such a high plane scientifically and educationally as that through the process of training in these schools there shall emerge young men and young women who are capable of studying the medical problems of China and of producing a medical literature for China, and who themselves will become the teachers of the future generations of Chinese in the very best that modern medicine can offer."—Dr. Betterick, of the China Medical Board.

Dr. Francis McLean has arrived in Peking to take up his duties as Dean of the Union Medical College, Peking, under the China Medical Board.

NOTICE.

BIENNIAL CONFERENCE.—The next Biennial Conference of the China Medical Missionary Association will be held in Canton, 1917, January 18th-24th inclusive.

SHANGHAI MUSEUM.

Snakes, lizards, tortoises, frogs, and newts are wanted for the Museum. If you are willing to help, please keep a big wide-mouthed closely-covered bottle containing 75% alcohol (or strong samshu) for dropping such specimens into. Towards the end of the year place the specimens in a tobacco or grocer's tin just wrapped in a piece of cloth moist with strong alcohol and send by Parcel Post. A few notes as to where found, etc., will increase the value of the gift. Out of pocket expenses will be gratefully paid on receipt of particulars.

ARTHUR STANLEY, Curator.