

The College Journal

Kansas City College of Osteopathy and Surgery

Vol. 19 No. 9

September 1935

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YOUR ATTENTION

is called to two books published by the Kansas City College of Osteopathy and Surgery:

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A book that is now used as the official text in several osteopathic colleges.

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KANSAS CITY COLLEGE OF OSTEOPATHY & SURGERY

Kansas City, Missouri

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The **COLLEGE JOURNAL**

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STANDING ROOM ONLY

On August 1st a sign was placed on the door leading to the class room to be occupied by the class starting on Monday, September 9th. It reads: "Standing Room Only". It means just what it says. The class is full, had 60 in it on August 1st.

We have been warning our prospects to "get their seats early". Now every seat is taken. It was inevitable. We have established our waiting list. Applicants are now being considered for September, 1936. Late applicants have choice of two alternatives: (1) applying for entrance next fall or (2) being referred to some other college.

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OUR HOBBY—(Continued)

And to continue my story from the Lake of the Ozarks where I am having a wonderful vacation while my assistants in Kansas City are sweltering and keeping the office work of the secretary moving: A most welcome interlude in my vacation was a visit by Dr. Mamie Johnston, our treasurer, and my assistant, Dr. Leanora B. Johnston and their grand old mother.

They came to give me a personal report on their activities, for the work preliminary to starting construction on our hospital together with the formation of our September class have been delegated to these two good doctors and to Dean Peach during my absence: And they have been doing a right good job of it. By the time this appears in print active work on the hospital should have been started, and the class for September, 1935, should be completely filled, for the latest report is that 46 have already been accepted as matriculants.

And just today I was delighted to receive in the mails a copy of "The Collected Papers of Dr. George J. Conley". I think I have already read every word this wonderful man has ever written. Most of it has appeared in our College Journal and in the preparation of this each month it has been my duty to read copy and proof for each issue several times. Yet I opened this book today and spent several hours browsing among its pages. Many may pass up the opportunity to purchase this book for Five Dollars. My copy cannot be purchased for One Hundred Dollars. "A word to the wise is sufficient."

Since I am on vacation I can write only a paragraph or two at a time, then I have to pause and rest from my labors. Just today, I had a letter from the office appraising me of the fact that the "class is full" and asking me to frame a letter of regret to the late applicants. And, believe me, that was the hardest letter I have ever been called upon to write. Whenever anyone expresses the slightest interest in studying osteopathy, it is my want to work day and night to convince that person it is the thing to do. I sometimes express myself thusly in regard to the proposition. "If I say or do anything that helps you decide to enter the osteopathic profession, I have done you a favor you can never repay. You are under everlasting obligation to me." And I mean just

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that. And now I am called upon to write a letter saying: "I'm sorry, you are just too late." But that is the truth and certainly I cannot be blamed for that.

And then this letter from Dr. Leanora Johnston had a suggestion that, at first blush, rather appeals to me. You folks out in practice no doubt know that some students never weather the first year of the osteopathic course. And quite a few find the sophomore year impossible. If they successfully pass the second year, few ever are required to drop out due to scholastic inability. The losses are greatest the first year and about on a par the second year. At least, that is our experience in the Kansas City College of Osteopathy and Surgery.

Now the suggestion is this. Since there are more students applying for admission to the Aggressive College than we can possibly accept and since we are trying to maintain a high standard and have the experience, one I am sure is not unusual to all colleges, that we accept a certain number of students who prove misfits or at least not quite up to the standard we desire, why not accept more than sixty in the freshman class, say eighty or even ninety. Since that size class is too large to give proper instruction to, divide it into two freshman classes, class A and class B, employ additional instructors and give each class an identical course. At the end of the year, sixty of the best of these 80 or 90 could be selected to form the sophomore class of the following year. By the time a few of those flunked out in the sophomore year, we would have our class reduced to the fifty we wish to graduate each year. The surplus freshmen found undesirable for our sophomore class would be invited to look elsewhere to continue their course of study.

Now, folks, I am telling you all this because I want your reaction to the plan. You are, or should be, as much interested in this college as I am. It is as much your school as it is my school. We want it an ideal school. There are more people wanting to attend our particular school than we can properly accommodate unless some such plan is adopted. Maybe they won't be lost entirely to osteopathy—maybe they will. Already we have had three persons inform us when told we could not accept them this year that they would not go to any other school. They also refused to matriculate for next year. Will they lose interest and be lost to osteopathy because we cannot accept them at this time?

Your helpful discussion of this matter will be very welcome.

A. A. Kniser, Secretary.

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PUERPERAL INFECTION COMPLICATIONS

L. A. Peterson, D.O.

There are two dangers facing the puerperal woman, infection of the breast and infection of the genitalia. Of course the woman at this time may contract any local or general disease, such as pneumonia, typhoid, or any skin disease, however, the puerperal infection is of greatest importance.

Among the complications at this time are the following:

Puerperal fever is a general condition resulting from infection as any surgical wound might be infected. Many bacteria being present in these cases, these infections may be either endogenous or exogenous.

The exogenous type is by far the most common and the first to think of when the temperature rises. The most common carrier of these infections are the physician, mid-wife, and occasionally the nurse; even the dust of the air is a carrier.

Pregnancy in itself favors the attack of bacteria which may be perhaps explained by changes in the liver, kidneys and the demineralization of the tissues. Tests show animals to be more susceptible to infection at this time.

Prolonged labor, especially after rupture of the bag of waters, because of frequent explorations of the vagina and the greater time and opportunity for bacteria to wander upward, increase both the frequency and the severity of the infections.

Vaginitis is caused by traumatism during labor, use of too hot douches, or caustic antiseptics. The symptoms are swelling, heat, and general symptoms of infection. Vaginitis is never present without vulvitis. Internal examination is prohibited. The Elliott treatment should prove valuable in these conditions. With any infection of the vaginal tract there is usually an accompanying endometritis.

Endometritis. The infection may

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have been already present in the endometrium during pregnancy. The symptoms of this condition are negative for the first two or three days then there shows up indications of trouble brewing; unrest, malaise, pain in the uterus—recurrence of after pains after their original subsidence. On the third, fourth, or fifth day there is a chill, sometimes slight with rise of temperature, anorexia, headache, pulse from 100 to 140 per minute, and the temperature from 101 degrees to 104 degrees Fahrenheit, depending on the severity of the condition. The uterus is large and soft, there is usually abdominal distention but no tenderness of the abdomen. The lochia is watery becoming serous and caustic causing irritation and ulceration. If the symptoms are not severe the temperature pursues a remittent course for four or five days subsides by lysis, the pulse slows and in six to ten days recovery is established.

Phlegmasia alba dolens (Milk leg). Phlebitis of the extremity is another condition which should be discussed. This term is rather loosely applied to several different pathologic conditions. The term means a painful white inflammation and applies to such occurring in the thighs and legs, although it may occur in the arms. Different forms have been observed, i.e.,

(A) Simple thrombosis of the femoral vein, saphenous vein or the iliac with edema of the leg beginning at the foot and extending to the body or trunk. It presents slight fever, slight pain and in general very mild symptoms. The skin is mottled with distended veins and feels cold to the touch. This thrombosis is said to not occur without infection, although the source of infection may be quite remote.

(B) Thrombophlebitis of the pelvic veins may be the outward extension

of infection in the uterine veins. In this condition the beginning chill is followed immediately by localization in the leg while in the simple thrombosis the symptoms and signs of endometritis or pelvic inflammation precede the pain and swelling of the leg. After a few days the pain settles in the groin and the calf of the leg. The pain is extreme. The thigh may swell to twice the normal size within a few days and the whole leg becomes involved. There is a milk white appearance which gives it the name "Milk leg".

The first consideration in the treatment of "Milk leg" is prevention. Extreme aseptic conduct of all obstetrical cases aid in the prevention, though it may occur under the most perfect management. Contrary to old ideas the patient, during normal puerperium, should be directed to take exercise, after the second day increased daily during the days following labor. Some German authors say the patient should be gotten out of bed on the second or third day. This is said to improve circulation and prevent the formation of thrombi.

The patient must be made to realize that she is to lie in bed until all trace of swelling is gone, and if recurrence after exercise she must again lie in bed. The leg is elevated to facilitate drainage and any movement is discouraged to prevent pulmonary embolism. The value of osteopathic treatment must not be forgotten. Although there should be no manipulation of the affected part, the lumbar area should be well treated, and splenic stimulation given regularly.

A fatal termination from this condition is rare, the most common being a pulmonary embolus.

A PERSONAL EDITORIAL Calmness and Calamity

There is not a whole lot of difference in the spelling of these two words but there is a great difference in their meaning. Can you take it on the chin and come up smiling. Getting it on the

chin is calamity; coming up smiling is calmness.

An intractable illness has left me a cripple with constant suffering. I do not complain and bemoan my fate. I put up with it in an attitude that attracts comment. What is the use of worrying and complaining? Why not be calm about it?

Previous to the depression I considered myself quite comfortably fixed. Friends thought of me as a rich man. My books showed quite a considerable figure. Some people still think I am rich. I know better. I know that I am comparatively poor. Yet, do I mourn about it? Hardly. Richer men than I was are now in the bread lines. They were smarter business men than I ever accounted myself to be. Yet, I am still in the running. I am still happy. I am calm in the face of calamity.

A few weeks ago I had about half completed a costly floating boat house. It was to be the envy of both friends and competitors. It isn't floating now. It sank. Did I rave and tear my hair? No, I did not even say "damn" or "pshaw." Maybe I sighed—I do not recall. A structure with \$1,500.00 in it under the water. An additional cost of \$500.00 when and if we get it up again. That was a calamity but I can and am being calm about it. My business last summer was a "hum-dinger." This season it is rotten. Well what is the difference? I am living, as happy as can be. I am calm about it.

My friends tell me practice isn't what it might be. People have no money to spend on their health. They haven't money to spend on anything, unless it be a little pleasure, like buying an automobile or a radio. Well, let them be happy and be happy with them, even if this is proving a calamity to you. Why should you let a little depression and its concomitant evils cause you unhappiness. Be calm about it. I am sure that is the reason I have noted the depression probably less than any other living individual. I simply would not let its calamitous influences disturb my calmness.

A. A. Kaiser, D.O.

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SOME PROBLEMS IN ETIOLOGY

Yale Castlio, D.O.

There is a noticeable tendency, prevalent throughout the medical profession, to consider a diagnosis as made when, after sufficient study, it has become possible to apply to a combination of symptoms presenting themselves in a given patient the name of a disease. This tendency is most obvious, and understandably so, in students of medicine; but it is hardly less apparent in superficial practitioners of all ages and degrees of experience.

Such terms as gastritis, sinusitis, neuresthenia and allergic rhinitis are commonly put forward as diagnoses with obvious satisfaction and ponderous finality on the part of their advocates as though, in themselves, these words implied an understanding of the offending pathology and a knowledge of what to do about it. Less frequently, but too often, we encounter such diagnostic jewels as myalgia, goiter or arthritis, standing alone, unadorned with qualifying adjectives, representing perfectly their users' understanding of the conditions they imperfectly describe.

It is difficult to impress upon students, and certainly many of them never receive or retain the impression, that the conceptions embodied in such general terms seldom constitute a diagnosis until they can be qualified by the words, "due to—".

Under some circumstances this qualification is, of course, unnecessary. In the face of an acute appendicitis we are little or not at all concerned with its cause. But in order to have an intelligent understanding of or offer a rational treatment for the vast majority of symptom complexes something more than the correct name for them must be discovered, since nearly all diseases may be most successfully handled by directing attention to one or two of several possible causes. Exophthalmic goiter or

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neuresthenia, for example, may exist as the result of any one of a number of etiologic factors requiring radically different therapies for their control, and having nothing in common except their ability to induce the disease.

A failure to appreciate this fully leads to careless examination, superficial diagnosis and therapeutic routinism. This type of professional laxness is, or at least should be, more prevalent among allopathic than osteopathic physicians, since the latter are taught that a given disease constitutes an etiologic problem to be solved rather than an aggregate of symptoms to be controlled.

This effort to find the correct qualification of a general diagnostic term to fit a given case is, of course, the most difficult part of a physician's work. To make the attempt without success is understandable; but to neglect the problem entirely or fail even to recognize its existence is inexcusable. The general prevalence of the habit must be laid to faulty instruction or mental sluggishness.

In the attempt to follow these intricate etiologic pathways in their ultimate ramifications the investigator, almost as a rule, comes to a place where knowledge ends in an experimental bridge incompletely spanning a gulf of speculation. One type of practitioner never gets close enough to the bridge to glimpse it. Another is constantly misled by the illusions that pervade the fog in the gulf. A continual procession of therapeutic fads presses on over the far end of the incompleting structure and is lost in oblivion.

Our knowledge of nearly all diseases is imperfect; of most of them, and some of the commonest and deadliest, it is woefully so. However comprehensive our knowledge, wide our experience and perseverant our studies, we are never able to command all

of the information that we could utilize in therapy. Many physicians, it seems, are smugly satisfied with this state of affairs; but the builders of the bridge are keenly aware of the gaps yet to be crossed.

In closing a masterly treatise on the etiology of tuberculosis, Allen K. Krause, of the University of Southern California, having discussed the tubercle bacillus itself and many additional factors of heredity and environment, states: "Put tersely, the problem is this: why do some people get active tuberculosis, while most, though infected, do not? Granting that the factor sine qua non of all tuberculosis is the bacillus, practical medicine today recognizes the etiology of tuberculosis as synonymous with the etiology of active tuberculosis, and, as a thing to be explained, regards it as a phenomenon distinct from the etiology of infection as such. The latter is apparently a relatively simple biological event; but its subsequent course is beset with many complexities which mould and determine its issue.—It is, indeed, the cause of clinical or active tuberculosis, as distinguished from the causes of infection as such, that constitutes the main problem.—We know the bacillus, its nature, its habits and its effects, singularly well. But the problem, 'What makes the case of tuberculosis?' remains unsolved and still commands as much interest as ever."

Joseph L. Miller, of the University of Chicago, writing on typhoid fever, comments upon the fact that "the blood of nurses who care for typhoid patients quite frequently contains typhoid bacilli in spite of the lack of any other signs or symptoms of the disease."

In his discussion of amebic dysentery, A. W. Sellards, of the Harvard Medical School, remarks, "It is clear—that a considerable number of individuals become carriers of *Entamoeba histolytica* without the appearance of any symptoms of dysentery."

Cecil and Plummer point out that

"The Rockefeller Institute workers have shown that a considerable percentage of persons intimately associated with patients suffering from pneumonia harbor in their mouths pneumococci of the same type as those in the patients."

These illustrations, chosen almost at random and capable of indefinite duplication, make clear the fact that even in cases of infectious disease, when we can isolate and study the causative organism and understand in a measure the tissue responses to its presence, there remain potent etiologic factors of which we are in ignorance. The pneumococcus no more explains the case of pneumonia, or the typhoid bacillus the case of typhoid fever, than the tubercle bacillus answers the question propounded by Krause.

In the study of most of the non-infectious types of disease these unknown quantities assume an even larger significance. Does the statement that diabetes mellitus is due to a failure of the pancreas to produce insulin in sufficient quantity really explain this disease satisfactorily? Why the failure? Several causes are to be found listed in standard medical texts; but they are inadequate to account for most cases of diabetes. Why should the thyroid gland in an apparently healthy individual suddenly begin to secrete thyroxin in abnormal quantity? An acute or chronic infection, thyroid feeding, a pregnancy or an emotional upset are all possible explanations, but explanations that fail to explain when applied in actual practice to most cases of thyrotoxicosis. Why do other individuals, exposed to these same influences, fail to develop thyroid disease?

Most of the causes advanced by medical authorities to explain the existence of disease require, in their turn, an explanation. We find too often in medical terminology such qualifying words as "cryptogenic," "idiopathic" and "essential." The answers to the more fundamental of eti-

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ological questions have eluded, and continue to elude, medical thought. In spite of the vast amount of talent employed and effort expended, etiologic investigations may still be properly described, in a certain sense, as perfunctory and superficial.

Allopathic thought is gradually drifting toward a conception that osteopathy has held and taught since its beginning, the recognition of which represents a long step-toward the understanding of the problems at hand. In its light such vague terms as general susceptibility and general resistance assume a new and more specific significance. We come closer to the answer to the question, "What makes the case of tuberculosis?"

The conception is this. There must be, in relation to diseases of nearly all kinds, some variable individual factor or factors capable of raising or lowering resistance, either locally or generally, and making easy or difficult the operation of more widely recognized causes of disease, both predisposing and exciting.

That combination of talent and circumstance that permits an individual to work upon and add to the structure of the experimental bridge mentioned above is infrequently found; and the contribution that any one man can make is usually small. A board is laid, or a nail is driven. When Dr. Still developed the conception of body mechanics and body immunity, and when he added to this the discovery of the osteopathic lesion, a whole span was erected.

Just how near to completion his work carried the bridge it is, as yet, impossible to say. There has not been sufficient time or sufficient opportunity for proper evaluation. Within our own ranks there is rabid enthusiasm and rank heresy. It is certain, at least, that in the beginning we were over-confident. The lesion is not the *sine qua non* of disease; nor does the ability to correct it afford us a panacea. The search for the "universal specific" in therapy must still go on.

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On the other hand, it is equally certain that one variable individual factor of great importance has been discovered and, in a measure, brought under control. We are justified, as a separate and advanced school of therapy, by our use of this in addition to other methods of disease detection and correction. We may be proud of the fact that in a very great many cases, when diagnosis has arrived at the point where a general term must be followed by the qualifying phrase, "due to —", we, and we only, can supply the deficiency in knowledge expressed by the blank with the term "osteopathic lesion."

It is the
"Aggressive College"

★ ★ ★

Kansas City College

of

Osteopathy

and

Surgery

MIDDLE CLASS HOSPITALIZATION

The very rich and the very poor have no difficulty in providing themselves with the facilities of the modern, standardized hospital, the former by virtue of their ability to buy what they want in the way of hospital service while the latter have the same advantages given them.

It is the middle class, the wage earners and the small salaried people, who are up against the real problem; for they have only the extremes from which to choose, and in the majority of cases the municipal hospitals and charity institutions are closed to them. At best, they must either choose that which is beyond their reach financially or deliberately class themselves with the paupers and accept charity. They must either stultify themselves in their own eyes by accepting assistance or bankrupt themselves in their attempt to maintain their independent standards.

The situation is acute. It presents a serious economic problem for it strikes at the masses that make up, for the most part, the producing classes. Not only are they virtually deprived of hospitalization but their medical protector, the family physician, is rapidly becoming extinct. In a few years the problem of medical care for the great producing classes will devolve upon the state unless another remedy is found.

Even now in some states, state legislation is being urged to assist students who will qualify for the general medical practice, with the proviso that they locate in some designated rural community for a stated period of years, giving bond to the amount of their professional educational expenses that they will so comply.

The solution of the problem of the general practitioner is not in state aid, but lies in the abridgment of the medical course in respect to time, money and didactic requirements.

Hospitalization and medical protection for the middle classes go hand in

hand. Philanthropists and charity-minded people have educated the laity out of all normal hospital perspective. Mahogany and marble, research work, graduate special nurse service on twelve or even eight-hour duty, the heavy overhead laid down by standardization, all have no place in the hospital designed for the modest financial pocketbook. That hospital must be stripped of all the unnecessary. It must be planned as one would build a racing automobile. All of the essential parts must be put in from the standpoint of utility; not to please the aesthetic senses. The equipment that is essential should be the best and most serviceable obtainable.

Upper class student nurses should be assigned for special service on these patients, or group nursing on the wholesale plan adopted. The management of such a hospital should be hotel trained, with adaptations for hospital practice. The latter phase is most important and represents the weak spot in most hospital machinery. Trained, efficient management will turn most hospital deficits into dividends. The time is long since past when a broken down preacher or doctor who cannot make a "go" of practice is considered capable of managing a hospital. It is not a job for a nurse, either.

Much of the laboratory folderol and statistical services found in standardized hospitals have no place in the middle class institution. This kind of a hospital should be stripped down like an athlete ready for competition. All of the non-essentials must be eliminated. Then, with an experienced man at its head, the machine will be in a position to give a good account of itself in scaling down hospital expenses.

Endowment to provide a fund to make up the deficit between a moderately priced bed and the actual cost of sustaining it, proposed by many people in many different places, is

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not the solution. Such methods cater to extravagancies and waste. The idea actuating the philanthropists is a laudable one, but, in the last analysis, it is a start toward pauperizing a class that has always prided itself upon its independence and that has always been the mainstay in the maintenance and integrity of the nation.

Those who advocate such plans approach the proposition from the premise that it is impossible for the middle class man to pay for his medical service out of the stipend which he receives from his daily work; that adequate service in a modern hospital cannot be produced at a figure within reach of the man of moderate circumstances; that provision must be made by endowment or appropriation to take care of the deficit between that amount which he can afford to pay and the actual cost of such hospital service. That trained minds and practical business heads should accept such an anomaly as an incontrovertible fact without inquiring into the reasons leading thereto and ascertaining the possibility of correcting them, is astonishing.

There would be just as much sense in making similar provision for people who, traveling for business or pleasure, patronize fine hotels beyond their means as for those who, from necessity, are compelled to resort to accommodations in "hotels for the sick" that are built beyond their reach.

Hotels and hospitals are allied businesses. The fundamentals of business management underlying each are the same. Both are caring for the traveling public. What matters if the one looks after the needs of those traveling for pleasure or profit while the other caters only to the man in search of health?

That there should be grades of services in hospitals to meet the necessities of the pocketbook is just as paramount as it is in the hotel business; but no one views the proposition from that angle.

Fundamentally, the existing trouble

lies deeper. To correct the difficulty one must attack it at its roots. The evil arises in the standardization of medical hospitals and schools. It is here that changes must be initiated that will lighten the burden of the middle class sick, and, if they are to be saved from medical pauperism and be allowed to pay their way, the problem will have to be attacked from that premise.

Standardization of medical education by lengthening the course and increasing the entrance requirement to medical schools, by packing the curriculum with highly technical instruction, by increasing the intellectual requirements beyond the needs of the eighty to ninety per cent of the public afflicted with "general" diseases, by increasing the expenditures concomitant to the acquiring of a medical education and by postulating the necessity of intricate, time consuming, highly technical laboratory methods in diagnosis and treatment, has resulted in turning out graduates that are educated away from family bedside work. This highly trained medical product can neither meet the exigencies of such a practice, nor can they afford to give the time for such work for the amount of fee the middle or poorer classes can afford to pay. Is the solution to be found in a subsidy for the doctor to supplement that which these people can pay in order that he may receive a fee commensurate with his standing intellectually? The answer is no!

Standardization is all right; but it must be remembered that the function and object of the medical school must be to prepare men for the treatment of the sick as its ultimate aim. Its educational standards must contemplate that end. The student must receive instruction that will enable him to cope successfully with the great mass of the diseased conditions he contacts. His time and money spent for such qualification must be minimized to a point sufficient to meet such needs. In short, medical schools

must specialize in turning out general practitioners who are prepared to meet the "grim reaper" on the ground of his choosing, at the family bedside.

The public will be amply safeguarded by medical authorities seeing to it that the term, specialist, means something. Let his training be as highly technical as it will. Make his intellectual punishment fit the crime!

Shorten the medical course! Make it practical! Stress the fundamentals of bedside work. Eliminate all of the highly technical and unnecessary procedures and minimize the expense. Turn out family physicians instead of intellectual highbrows who know everything but the obvious. Deliver a product that is distributable.

The standardized hospital is the next point of attack. Philanthropists, well meaning medical authorities, scheming medical politicians and over-enthusiastic business men, clubs and societies have educated the public to consider as essential many easily dispensable hospital accessories. Ornate fixtures are not necessities. Neither need the overhead be jammed with a highly trained technical staff. Every department of the standardized hospital is loaded with deadwood, in so far as the requirements of the sick are concerned. Research work is not only encouraged, but openly demanded. The idea of making sick people well in a hospital has been made subservient to the acquirement of the details of the scientific aspects of the disease with which they are afflicted. All patients are ground through the same hopper, regardless of conditions or circumstances. The end result of such a system is an augmented personnel, and an overhead all out of keeping with the actual needs of the patients.

Most hospitals are chartered as non-profit, tax free institutions. As such they are supposed to carry a certain proportion of charity beds, from none at all to as high as thirty per cent or more. These charity patients represent a liability which must be caught up and provided for by the revenue

from pay patients. This obviously places a heavy as well as unfair burden upon them. It compels them, indirectly, to do charity work with which they have no concern and no responsibility at a time when they can ill afford to do it.

The middle class hospital should carry no charity beds; neither should there be any attempt to do any research therein. As in the medical education, there should be a stripping to essentials. It must be designed primarily for the care of the sick. The stamp of mediocrity or inferiority must not be placed upon it by arbitrary ratings from a committee which has no legal standing and which might be biased by personal prejudice. The standing must be based upon the actual service the institution gives to the sick patient, the results they obtain with him. It should be judged by its fruits, rather than by the appearance of the tree that bears it.

Middle class people can pay for their hospitalization without outside aid. These people are not asking for charity. They ask for a chance to pay fees within their ability to provide. To that end, hospitals must be designed and service furnished to meet such conditions.

And it can be done!

What could be more attractive than the chance to work out the solution of such a problem; to demonstrate that the problem is one of management rather than endowment or charity; that as a purely business proposition it is possible to provide such a service at a modest cost and at the same time provide for a reasonable carrying charge on the investment?

The osteopathic profession has such an opportunity. The osteopathic hospitals can easily be made the instruments for experimentation. What they need is the volume of business to insure economic, efficient management to the end that there may be efficient service with the minimum of expense.

There is sufficient business origin-

ating in osteopathic sources to make this possible. The solution is entirely in the hands of the general practitioners. It is merely a matter of co-operation and mutual protection against our common enemies. Is not such an objective well worth striving to attain?

The article above is extracted from "The Collected Papers of Dr. George J. Conley." It is a fair example of the versatility of this great instructor. The medical profession has had its Cabots and other great writers. The osteopathic profession has only one, Dr. George J. Conley. He has just recently retired from the presidency of the American Osteopathic Association. But that retirement does not end his service to osteopathy. Tomorrow, next week, all the years of his remaining life he will be found on the firing line, giving his all to osteopathy. You should have this book of his writings. You will profit from every minute you spend reading its pages. It was published by the College of which he is president during his presidency of the American Osteopathic Association because we thought it an honor due him. You may have a copy for Five Dollars. You will never spend Five Dollars which will bring you more for your money than you ever received before.

A LETTER OF INTEREST

Dear Doctor Kaiser:

Since we parted from you in the beautiful Missouri Ozarks we have had many delightful experiences.

To travel through the several Mississippi Valley states between Kansas City and Cleveland and observe as we did the bountiful crops, the well improved farms and the "cattle upon a thousand hills" is to be impressed by the limitless resources of our country. To continue travel through Pennsylvania, New York and New England along mighty lake shores, over mountain ridges, across huge canyons or alongside challenging waters on their way to the sea in the form of most beautiful rivers emphasizes anew the rare beauty of our land. To see the extensive evidence of such activities as the huge coal mines at Scranton, Pennsylvania, or those of shipping, fishing, etc., along the coast for example at Boston convinces one that the wheels of industry are truly turning. To observe the thousands upon thousands of automobiles (fine new ones) that speed along the lovely four lane slab roads in thickly populated areas, that fill endless streets in the cities and block to overflowing spacious parking stations and to consider the operating expenses of these cars

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convinces one that we are a prosperous people. To have pointed out for us visitors, points of historical interest which abound here, kindles afresh the same strain of patriotism which filled our youthful blood streams when the teacher recited "Paul Revere's Ride."

Political situations in this country doubtless leave much to be desired, social evils undoubtedly retard our mental and moral progress and mighty economic problems are yet unsolved but surely we are progressing. Anyway, I am glad to be an American citizen and trust that I may be worthy of the heritage of our forefathers and that I may, in a measure, deserve the privileges and opportunities which I enjoy.

Perhaps you have before now had presented to you reports on the Cleveland Convention. In every particular it was one of the very best ever. It was well attended, there being some 1,600 in complete attendance. The entire program was most excellent. I spoke to several representative members about the idea that you and I have of entertaining the American Osteopathic Association Convention in the Missouri Ozarks, where there would be no programs, no business sessions or formal occasions. They seem heartily in

favor of the plan but so many of these convention people are so in the habit of preparing a manuscript or two before they go and spending the week shopping and exploring around the exhibitors' booths that they could never be happy without the routine procedure of conventions. So I presume we shall compromise by entertaining the A.O. A. in 1937 in Kansas City. I am sure that we can do it creditably.

More than ever before, I am hopeful of the continued expansion of osteopathy. It is a marvelous science, founded upon "precepts which have never been discarded or supplanted," taught and practiced by the finest men and women of the land and perpetuated by a group of colleges in which for the most part the students are sincere and the faculty members earnest and capable. I have seen and visited several marvelously well equipped, highly endowed medical institutions which appallingly contrast with ours but am not discouraged or dismayed.

In fact I was never before so enthusiastically bent on training more and better doctors of osteopathy by the methods which we use at the Kansas City College.

The Cleveland Convention was a delightful event and surely sent everyone in attendance homeward more exultant than ever before about osteopathy and more determined to carry on. I wish you might have seen the group of osteopathic technicians from the Chicago College exhibit their team work. Fifteen osteopathic treatment tables were distributed over the floor in the Cleveland Hotel ball room with a technician at each table demonstrating to "close up" groups the work explained and introduced by the platform man. Although it was presented at the end of a busy hot day from 8:00 to 10:00 P.M., the room was filled, interest in it was keen, the presentation was excellent and its worth apparently thoroughly appreciated by those in attendance.

Particularly did I enjoy the Bureau of College sessions. Certainly the future of Osteopathy is secure while such keen minded, unselfish—spirited individuals as sat around that table day after day are directing its educational activities. I have sat around this table for several years and am impressed by the progress that is being made by this group as well as by the spirit of cooperation between the various Colleges and the good fellowship which exists among the members of the group.

The Cleveland Hotel is an ideal place for such a meeting and the management knows how to make guests comfortable. Also the Cleveland doctors of osteopathy left nothing undone to make us happy and comfortable.

To me it has been a matter of great satisfaction to visit several of our hospitals which are well reputed. We have been well received, in fact treated royally and have found these institutions busy interesting places. We find these other people all interested in all of the rest of us including the Kansas City unit. They all inquire about the College Clinical Hospital and almost invariably make favorable comment upon the Journal which you publish monthly. By the way, my contribution will be missing this month but I understand that some obstetrical articles have been presented by others and I shall endeavor to be with you next time.

We have been in Boston for a week and are going on to Philadelphia next week where we anticipate a good profitable time there visiting the College and Hospital.

Although we are having a most enjoyable satisfactory trip the best part of it will be getting back and getting to work again.

Trusting that the new hospital is progressing and that the summer staff members at the college are well and happy, I am,

Sincerely yours,
Margaret Jones, D.O.

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1934 YEAR BOOK OF PEDIATRICS

Annie G. Hedges, D.O., of the College Staff.

Etiology of Mongolism

A. J. Rosanoff and L. M. Handy (Am. J. Dis. of Child. Oct., 1934) point out that etiologic factors in mongolism are narrowed down to those which must be at work in the germinal or early embryonic period. Statistics show a definite relation between the age of the parents and mongolism. The claim is made that the most important etiologic factor is the age of the mother. Mongolism is more common among boys than girls and they add: "This finding is so constant as to force the assumption that, although injury to the ovum is the essential cause of mongolism, the spermatozoon is not without its influence. The x-chromosome in the female-producing spermatozoon seems to have, in some cases, the power of protecting an injured ovum against its tendency to develop into a mongolian child. In this connection it is pointed out that mongolism varies greatly in the severity of its manifestations and is, on the whole, milder in girls than in boys, possibly owing to partial protection by the additional x-chromosome."

Influence of Season on Disease

Pierre Woringer, in a paper read before a pediatric association in Paris, 1934, notes that Hippocrates recommended the study of meteorology to establish the origin of disease. Scientific study is now being made of "meteoropathology" but will necessitate collaboration of doctors and meteorologists.

Fatal Alcohol Poisoning in Infants

M. Schachter and O. Sraer (Arch. Dis. Child. Aug., 1934) report the death of a ten-week-old infant which had previously been a healthy, normal breast-fed baby. Investigation revealed the fact that the mother had drunk several glasses of whiskey and a small amount of wine the day before and had nursed the child in the evening and the next morning. The child suddenly became ill with convulsions,

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vomiting and diarrhea, and died in a coma. They also report a similar case in a child of six and one-half months.

Accidental Poisoning in Childhood

John Aikman (J. A. M. A., Sept. 1934), states that more than five hundred deaths from acute poisoning (gas excepted) occur during the second year of life and one-fifth of this number during the third year. He states that "strychnine poisoning due to brightly-colored sugar-coated cathartic and tonic tablets causes more deaths in children than any other poison."

The Discard of the Cradle

John Zahorsky (J. Pediat., May, 1934) is impressed with the fact that so few pediatricians make use of more modern psychological methods, which are of decided benefit in the care and training of infants and children. He says: "Pediatricians have really done harm by the excessive emphasis placed on the possibility of 'spoiling' the child." And that no infant of five months should be placed in his crib, given his bottle and then left alone in the room with no more attention paid to him. He adds: "This is not care; it is absolute neglect of the infant." He contends that rocking the baby has a beneficial effect in a number of ways. "It has a cooling effect, since the motion acts as a gentle fan and hastens evaporation from the skin. The gentle swaying motion has a soporific influence. It is distinctly soothing to the excited nervous system." Abt in an editorial says Zahorsky has entirely missed one effect and that is the assistance to the pendular movements of the intestine. He says: "In addition to chyle, the intestine always contains gas, and the swinging movements of the baby's body causes liquid chyle to gravitate backward and forward over the intestinal mucosa. Rocking, therefore, is a physical therapy which aids digestion and probably absorption. * * * But the author

has obtained the clinical impression that young infants who are rocked after nursing have as a rule less colic, less enterospasm and become happier babies than those laid in the crib without rocking." (It has been our experience that babies who are handled and talked to or played with to a reasonable extent, also develop better mentally as well as physically than those who are raised "by the book" and who are left much to themselves. On the other hand, too much excitement is injurious to the nervous system and digestive and absorptive functions always suffer when the nervous system is involved to any great extent.—A. G. H.)

Syphilis

It has long been the hope of pediatricians to evolve a better method of the treatment of syphilis in infants and children and many experiments have been made in the hope that some form or oral therapy may be found which will be effective and a number of interesting reports regarding the use of "Stovarsol" or "Acetarzone" (synonymous terms) will be briefly reviewed here. This drug is a preparation containing from 27.1% to 27.4% of arsenic. The dosage is as follows: The first week, 0.005 Gm. per kilogram of body weight daily; the second week, 0.010 Gm.; the third week, 0.015 Gm., and the fourth week, 0.020 Gm. For the next five weeks the dosage is 0.020 Gm. per kilogram of body weight daily. This nine weeks' treatment is followed by a six weeks' period of rest, after which the treatment is repeated if necessary. It is dissolved in a little water or better, milk, and given a half an hour before meals or before feeding time. If the quantity used is small it can be given in one dose daily, but when larger amounts are used it may be divided into two or three doses daily.

Alvin C. Rambar (J. Ped., Dec., 1933) advises the use of this treatment early in all cases of congenital syphilis and recommends that all children of syphilitic parents should be

given this treatment as a prophylactic, even when syphilis does not seem to be present.

Alfred S. Traisman (Am. J. Dis. Child., Nov. 1933) reports results obtained by him in the treatment of 54 cases of congenital syphilis by this method. After the first course, in children between the ages of 1 and 6 years the Wasserman reaction became negative in 55% and the Kahn negative in 33%. In children between the ages of 6 and 12 years the Wasserman became negative in 47% and the Kahn in 19%. Following a second course of treatment the percentages of improvement were greater. Clinical symptoms and physical development improved markedly in all but one case which developed urinary disturbance and arsenical dermatitis. Bone lesions healed rapidly in all cases.

Joseph Yampolsky (Am. J. Dis. Child., July, 1934) reports his results in the treatment of sixteen children. All of these patients had at least one course of treatment and some had more. He says: "The three cases of syphilitic keratitis cleared up as well as could be expected under other forms of treatment." Otherwise, his results were similar to those obtained by other investigators.

John F. Coppolino (Am. J. Dis. Child., Oct.-Dec., 1933) says that this drug is well tolerated by infants and children and is administered with ease and "is extremely effective for young infants, both rendering them symptom-free and causing the serologic reactions to become negative. * * * It is equal to bismuth in its ability to heal lesions but appears to be superior in its ability to bring about an earlier reversal of the serum reaction. It appears to be the drug of choice for young syphilitic infants."

Abt remarks editorially that "Most of the clinical reports concerning the use of acetarsone in the treatment of congenital syphilis find that it compares favorably or in some instances is better than other forms of treatment."

(This form of treatment deserves a thorough trial in the treatment of children.—A. G. H.)

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SOME ARE PLEASED

Read these two letters:

Dear Dr. Kaiser:

Thank you for your prompt delivery of the new book, "Collected Papers of Dr. George J. Conley." I find it to be all that you said it would be—a book that any physician can be proud to have in his library, and one that will be always useful.

I hope that the Kansas City school will be able to continue such publications as this book and the one written by Dr. Castlio a year or so ago on Principles, and I assure you that when they do materialize I shall be among the first to purchase my copy.

Fraternally yours,

C. D. Hulett, D.O.,
Newport, R. I.

Dear Doctor Kaiser:

We are indeed grateful to you for your courtesy in sending to us copies of the "Collected Papers of Dr. George J. Conley" and Dr. Castlio's "Principles of Osteopathy" for our library.

We shall bring both of these books to the attention of our students and faculty. They are both excellent contributions to osteopathic literature.

Yours fraternally,

R. N. MacBain, Dean,
Chicago College of Osteopathy.

YOU WILL BE PLEASED

If you order either book

Collected Papers of Dr. George J. Conley

Price \$5.00

A book of 432 pages containing the writings of the recently retired president of the American Osteopathic Association. Every article is a gem. You have already read some of them. You will be delighted to read them again—and again. Edited by Castlio.

Castlio's Principles of Osteopathy

Price \$3.00

This was the first book published by the Kansas City College of Osteopathy and Surgery. It is now the official text on the subject in several colleges. No matter how well informed you are, this book should be in your library.

A.O.A. MEMBERSHIP CAMPAIGN

1935 - 1936

Under the guidance of F. A. Gordon, D.O., President of the Iowa State Osteopathic Association and Chairman of the Special Membership Committee of the A. O. A., the drive for members will not only continue but will take on renewed activity. The importance of this activity is permeating the professional consciousness to the extent that active interest is being evinced in quarters where before only a passive attitude was the rule.

The Cleveland meeting focalized the idea. The needs of the Central Organization were stressed. The means for its relief and for its needed expansion were shown strongly to be resident in our non-membership group. Everybody was cognizant of the immediate need of making them organization conscious. There was a strong sentiment for a more active campaign to bring them to a realization of their obligation to the necessity for their whole hearted support of the national organization.

Never at any of the recent conventions has this sense of Central Organization necessity been more spontaneous or more generally apparent.

At one of the meetings of the House of Delegates a member of that body, whose name unfortunately has slipped my mind, made a motion to the effect that the personnel of that body pledge themselves to the active support of the membership drive during the coming year. The motion was passed without a dissenting vote. Never before to my knowledge, has the House of Delegates gone on record in a similar manner.

Dr. Gordon is a "go getter." He has made an enviable record for himself as president of his state association. He built up its membership and increased the membership in the National at the same time by a plan of dual membership which he hopes to adopt for usage in his national campaign.

The members of the 1935 House of Delegates are already pledged to support the drive by their active individual efforts in their respective states. The Board of Trustees need only the word of President Thorburn to swing them into action. With such a nucleus Chairman Gordon ought to have no difficulty in building up an effective, militant minded, aggressive membership organization.

Two hundred members of the American Osteopathic Association pledged to bring in ten new members each will turn the trick. They will give Chairman Gordon all the members he needs to unlock the wheels of national organization progress. The revenues accruing from such membership fees alone will take care of all the immediate plans for expansion. It can be done easily. It must be done immediately. How many will volunteer to serve under Chairman Gordon pledging themselves to become responsible for ten new members each, one a month, counting out July and August for vacation.

Chairman Gordon, put me down at the head of the list and I am sure Hugh Conklin will be glad to take the next place. Get in the game folks and let's make Gordon's job an easy one.

Two hundred members, each pledged to run down, throw, hog tie and bring in ten non-members before the New York Convention! Get busy and let's get going!

George J. Conley, D.O.

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A CASE OF STRABISMUS

A. B. Crites, D.O., of the College Staff.

Miss G. C., a small woman, age twenty-nine, enrolled in the College Clinic in the spring of 1934. Her complaint was severe headaches caused by eye strain thought to be incident to her stenographic occupation.

Her cervical and upper dorsal were treated and lesions corrected, but this did not obtain for her permanent relief from the temporal and occipital pain.

She was again referred to the Eye Department. Her case history showed her eyes to have been crossed since babyhood, and the wearing of glasses since she was ten years old. Examination showed vision in the right eye to be 20/40, improved by her correction to 20/30. In the left eye visual acuity was 20/100 increased with correction to 20/50. She was wearing a plus 2.25 sphere, combined with a cylinder .50 at axis 90 for each eye.

The fixing eye was the right eye, although it was possible for her to alternate to the poorer eye, the left, when the right eye would turn inward. Having acquired the ability to suppress the image seen by the crossing eye she did not see double. The measurement of the deviation was 7 mm. on the corneal surface. While her fusion faculty was not all developed it seemed to require 35 prism diopters to superimpose the images of the two eyes at a distance.

Since she had an excessive convergence upon accommodation for objects at the near point, it was felt that her asthenopia and headache were due to this convergence excess. Twice as much energy is expended in convergence as is used in accommodation, and as they are associated functions, wearing the proper correction to overcome the effort of accommodation

at the same time relieves the excessive convergence effort.

The average case of strabismus does not have asthenopia, consequently the subjective eye strain symptoms in this case are quite unusual.

Miss G. C. was operated July 7, 1934. Under local anesthesia the left external rectus muscle was exposed and severed from its attachment to the globe, and recessed backward to a new attachment on the eye-ball near the equator where it was sutured to the sclera with catgut.

This amounted in principal to lengthening of the strong and over-active internal rectus. By weakening its activity, the external recti were permitted to regain their tone and to function normally.

After a few days exercises were begun to improve vision in the left eye, restore fusion, and regain stereoscopic vision. Fortunately these efforts were quickly successful, so that within three weeks a refraction was done. With the correction plus 2.75, plus .50, axis 90 for the right eye, vision was 20/20; and with the correction plus 2.00 at axis 90 vision in the left eye was 20/30 plus 4.

Periodic checkups have shown that the eyes are at all times straight, a small amount of right hypophoria and exophoria for distance has gradually become less and the eyes are quite comfortable though of necessity used excessively in the young lady's present occupation.

OUR LIBRARY

Just recently our library received a much appreciated donation from Dr. H. T. Kirkpatrick, Miami, Florida, which consisted of the following:

Medical Diagnosis—Anders.
Nelson Loose-leaf Living Medicine (9 volumes).

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GADGETS AND GEWGAWs

George J. Conley, D.O., of the College Staff
Surgeon-in-Chief—Lakeside Hospital

Years ago I remember hearing Dr. Charles Mayo say, when electricity first made its appearance in the offices of physicians as a treatment adjunct, that he felt obliged to use it on every case that came his way in order to realize interest on his investment. As it was then so is it now only more accentuated.

There are certain fundamental factors underlying the treatment of disease in any system of therapy. These principles must be taken into account and measures initiated that will work in accord with them if the best results accrue to the patient. Adherence to such ideals constitute ethical practice whereas marked deviations carry one into the realm of doubtful practices.

Andrew Taylor Still gave to the healing art, as improvements upon existing practices, the concepts of the natural immunity of the tissues and skeletal integrity. He designated these as basic factors in the etiology, prognosis and treatment of diseases. He demonstrated these postulates at the bedside. He satisfied himself beyond any question of a doubt that conscientious adherence to the principles as laid down in his system of therapy—Osteopathy—would be followed by certain definite results. The reputation of Osteopathy was established in bedside practice and was built upon medical failures. He accepted cases recognized as incurable by the conventional methods of treatment of his day, applied his methods and relieved their diseased condition. His results have been duplicated by his disciples the world over in countless numbers.

Being founded upon natural laws his system of therapy, contrary to most medical theories, had the quality of immutability. It was not the vogue yesterday and only a memory today.

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It is just as vividly alive, active, useful and dependable today as it was when he announced his discovery sixty-one years ago. Not only is this true but the clinical application of the osteopathic concepts, is as full of intriguing expectations now as it was in the years gone by. As it has become tempered by clinical usages it has acquired a flexibility of therapeutic purpose that widens the influence of its adaptability to a marked degree. By clinical study and by research its circumscribing horizon is being widened to include phases of disease scarcely contemplated by its original disciples.

The lesion is still subject to elucidation through study and research. Anyone can give the best of himself to its contemplation and find therein a challenge to his best mental endeavors. In osteopathy the neophyte has a vast amount of virgin territory awaiting his exploratory propensities while the seasoned practitioner finds entrancing vistas sufficient to maintain a perennial interest to him. Such then is the picture osteopathy presents to the inquisitive mind.

In the good old days, before the advent of adjuncts to the medical armamentarium, the physician had to depend upon his most primitive resources for information. He had to rely upon his special senses, his powers of observation, his ability in deductive reasoning and his intuitive resources, to achieve success. Time was when the doctor tasted the specimen of urine in order to determine the presence of sugar. The sense of smell contributed its quota of information in the diagnosis of certain diseases, while sight, hearing and touch were all valuable measures in acquiring a knowledge of disease conditions. Doctors of that time developed a keenness of observation, a

clarity of therapeutic thought and a clinical acumen, that carried them far in the recognition and treatment of diseased conditions, the causative factors of which they had little or no knowledge.

As the modalities of electricity became more refined, instruments of precision designed for research work or for other scientific purposes were developed and made accessible. Thus the machine age in diagnosis and treatment was inaugurated. The medical profession, already drug nihilists, faced with therapeutic failure, was quick to seize upon them as a substitute for their unscientific and discredited methods of treatment. So great was the need that any innovation in treatment, no matter for what purpose it was introduced, was regarded by many as a possible panacea and was used for everything from ingrowing toenails to wens. The harried physicians, like drowning men grasping at straws, made every possible use of a new remedial measure. Just so were the instruments of precision, scientific gadgets designed for special purposes, put to uses foreign to their original intention, in the hope that something of good might result clinically.

In the course of events, as ideas in salesmanship became standardized and as quickening competition compelled less stringent credit stipulations, the amount and variety of treatment adjuncts in the doctors' offices increased to that extent, that many offices gave the impression that an electrical engineer was a necessity, in order to manipulate and keep in repair, the numerous devices depended upon for diagnosis and treatment. As machines were installed the need to keep them at work became apparent to an alarming degree as the day for the first payment on them rolled around.

With the increase in the number of machines installed the need to use them developed combinations of such adjunct treatment and another inno-

vation was compelled, the office technician as an assistant. Obviously the doctor could not give of his time the amount necessary to follow personally each patient through the varied course prescribed. It was found that girls of average intelligence could be obtained at a comparatively low salary who could quickly be trained to manipulate the machines thus relieving the doctor to that extent. The patient, cognizant of the propaganda of machine age industrialism and easily receptive to the same ideas applied to the treatment of disease, readily became enthusiastic advocates.

Machine treatments as a rule are metered. As combination treatments were innovated more and more time was required in their consummation, hence the patient became impressed with the idea that it was very thorough, the very psychology of which carried with it the feeling of benefit. Naturally he confided his reactions to his family, his neighbors, his friends, and if he was a natural propagandist, he proclaimed it from soap boxes, house tops or from any point of vantage whereby he could get a hearing—and the machine doctor's business grew in proportion. More business entailed more machines which demanded more space and compelled more cheap assistants. The doctors' offices assumed the appearance of a busy machine shop, duly impressive to the prospective patient and an object of emulation for the less busy doctor. The transformation of the doctor to a case taker, a salesman of the super type, was comparatively rapid. How much easier, more important to the casual eye, to sell prospective patients the idea, make a few notes on a card and turn the patient to a technician. Thus the machine office in varying degrees is off in full swing.

The osteopathic physician, true to the art of his profession, accepting each new contact as an opportunity for service, patiently taking case history, noting lesions and points of

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diagnostic importance in a painstaking physical examination, associating them with salient points in case history, the personal attention necessary to reduce said lesions, the physical labor involved, the depletion of the vital energy of the doctor by hand contacting the patient, the necessary limitation of the volume of business through personal attention and the everlasting study necessary to determine etiology, pathology, prognosis and treatment, may view with envy his more prosperous appearing, busy competitor of the machine office type. It is natural to seek lines of the least resistance. It is only human to desire to increase the financial returns from a given effort. Hence it is that even an ordinary salesman at the proper psychological moment, might find it easy to interest such a doctor in the purchase of a labor saving device that would materially lighten his physical burden even though it did not increase his emoluments. As a rule this leads to other acquisitions of like nature, less attention is given to legitimate fundamentals and osteopathy suffers.

The age old admonition from the Master Christ: "No man can serve two masters; for either he will hate the one and love the other; or else he will hold to one and despise the other." Adjuncts have their place. They have a legitimate usage. They must not usurp the center of the therapeutic stage. They must not compel all thought and attention of the doctor to their possibilities. They must not assume the proportions of foundation stones in building a professional reputation. The tendency to put too much dependence upon things palliative at best and too little reliance upon corrective measures which make for permanency in therapeutic results spells failure for the individual and promotes professional decline.

Years ago, in 1901 to be exact, I received my diploma as a graduate in Osteopathy. I was filled with enthusiasm over the possibilities of

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osteopathy as a system of healing. I had planned to enter the general practice of osteopathy. Opportunity presented whereby I could avail myself of an assistantship in surgery. I accepted but not with the expectation of ever following it as a vocation. The idea was abhorrent to me. The sight of blood made me faint. The smell of the anaesthetic was more rapidly potent upon me than upon the patient. Just to hear a person in the act of vomiting constituted an insistent urge for me to go and do likewise. Pain and suffering in an individual always exercised its maximum effect upon me. In fact there was nothing in the realm of surgery that appealed to my imagination. I was the exact antithesis to all of its charms. But I wanted to know why the surgical wheels went around so I took service under a competent surgeon, overcame my antipathetical idiosyncrasies, served six years before I was allowed to take a knife in my hands and finally qualified as a major surgeon.

The urge of the general practice was that strong that I opened an office for that purpose. I was called upon occasionally to attend a case that had assumed surgical aspects. I spent my spare time and quite a considerable of it that wasn't "spare" in obtaining clinical experience in obstetrics, in acute work and in emergencies among the "fly by nights" over on West 12th Street, among the colored people in Belvidere Hollow, Hicks' Hollow, Cottage Lane, Maiden Lane and East 18th Street and worked among the Polocks, Slovacks, Italians and the poor white trash. It was all good experience.

My general practice increased. I had developed into a busy general man with surgery as an avocation. At that time I was the only osteopathic physician in Kansas City or its immediate vicinity who had qualified in major surgery, in the acute practice and in obstetrics. Surgical calls became more frequent. Such

service soon became a professional necessity. Calls came from outlying communities so eventually I was crowded into surgery as a specialty from professional necessity and not from personal choice.

At this period a young institution, destined to assume its place on terms of parity with the best of like nature in the Southwest country, was in the travail of birth. It was the Southwestern Osteopathic Sanitarium of Blackwell, Oklahoma. An insistent call for help came from its founder, H. C. Wallace, D.O., and in extending to him a helping hand I found myself pulled, willy nilly, into the troubled seas of institutional osteopathy. The die was cast and surgery won the day. From that time on general work was compelled to yield to the increasing demands of the surgical practise but the old urge has remained. The general practice propensity will not down.

Now after all these years of surgical experience it is most important that that accumulation of surgical wisdom be passed on to others that they may carry the light to even greater heights. The problem of furnishing surgical training to deserving aspirants is most important. It is a crying need. Institutional development goes hand in hand with competency and numbers in the primary specialty groups. So it is incumbent upon those who have had the advantage of specialty training to help in the training of others. The specialty supply however must not overtop the demand to too great an extent.

The machine age in diagnosis and treatment has had, as a natural consequence, the unparalleled development of specialty service. Scientific gadgets as diagnostic factors, caused doctors to combine forces so as to avail themselves of such necessities. Group practice became the vogue. As business came to the group it had to be divided, specialized, so that each individual would have a reasonable chance in sharing it. An immediate

over supply of specialists and a marked deficiency of general practitioners was the inevitable outcome.

In as much as the general practitioners' domain embraces from 80% to 90% of the cases he contacts with the remaining 10% to 20% falling in the specialty field, it is easy to comprehend what happened when 80% to 90% of the new graduates went in for the specialties. It needs no mathematician to figure the causes of the fierce competition in specialty practice today. It is easy to understand the reason for slashing prices, splitting fees, and the granting all kinds of concessions for reference of business. The eager chase for business has practically wrecked the specialty practice. It is literally shot to pieces. It has reached a point wherein there is no incentive to cause one to foreswear general practice, to undergo the mental effort, to give the time and to incur the expense necessary to qualify. The term specialist has been sullied by incompetency, dragged in the mire by avariciousness and has been dishonored by charlatanism.

Having come up through the field of general practice, having experienced it in all its changing phases, having faced handicaps in practice building as severe as anyone in practice is ever called upon to meet; having been successful in establishing osteopathic prestige in a small community where it had fallen into disrepute from philandering proclivities and incompetency on the part of previous osteopathic physicians, knowing specialty service as it formerly was and as it is now practised, I feel competent to pass at least an average brand of judgment upon the existing situation.

I am fully conscious that in condemning specialty aspirations on the part of young osteopathic physicians my motive will be misconstrued and I shall face the charge of selfishness and jealousy in a desire to minimize the number of surgical specialists in order to eliminate competition. Such

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is not the case. It would be a better business proposition for the Lakeside Hospital to have a dozen competent major surgeons of our profession (did a sufficient amount of business exist to justify them), sending their business to it than to have but three or four. Again I challenge anyone to cite a single instance where a competent reputable surgeon has been denied access to Lakeside facilities either from jealousy on my part or from a fear of competition that he might introduce into the local situation. I have been meeting successfully the vicious competition of the best of the surgeons of the dominant school too many years to fear that which might come from friendly sources within the ranks of my own profession. So what I am about to say is actuated by the best of motives and is dictated by that which in my judgment is best for the osteopathic system of therapy.

The greatest field of endeavor today in the healing art lies in the general practice of osteopathy. The easiest and most rapid approach to success in its true sense, in any community is through the gateway of the general practice of osteopathy. The surest way to financial security in the field of the healing art is in the development of a general practice of osteopathy. The general practice of osteopathy offers to the individual the widest range of independence: it affords an intriguing field for mental endeavor in the effort to master the intricate clinical manifestations arising from the osteopathic concept of the lesion.

The most exhilarating reactions emanating from any phase of the practice of the healing art lies in the solution, through the application of the osteopathic concept of the lesion, of a baffling problem in disease that has taken the measure of the best of the diagnosticians and clinicians to be found in the great clinics of the United States. The satisfaction to be found in the completion of any of

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the surgical problems the average surgeon is called upon to meet, is as nothing compared with the thrill that comes from this. There are thousands of competent surgeons and tens of thousands of competent specialists along the various lines, competent to care for the small percentage of cases coming within their domain. But there are numerous problems in general practice, baffling the best of medical skill, surgeons, diagnosticians and clinicians of world wide reputation, which, when subjected to the illuminating process of an osteopathic examination, yield their secrets in a manner most beautiful to behold and most satisfactory to the sufferer.

You, general practitioners of osteopathy, are the magicians capable of performing such miracles. You have the field to yourselves. You are the specialists of specialists. In the magic of your hands, backed by the "open sesame" of the osteopathic concept of the lesion, you have means at your command that open the secret hiding places of disease. It gives to you the reason for the point of low resistance in the tissues—the "ignis fatuus" of the research men. It simplifies the problem of the cure of disease. Its beneficencies are applicable to every specialty.

You have the therapeutic "Pearl of Greatest Price" within your grasp. You are privileged to use one of the greatest innovations ever given to the healing art. The use you make of it now largely determines the place of osteopathy in the therapy of tomorrow. You can go in it as far as your capacities will permit. Your efficiency will be self limited. As you become more familiar with the weapons given you by Dr. Still, through study and clinical experience, you will use them with increased confidence which will augment the zeal, enthusiasm and faith inherent in their possibilities with the inevitable result of more widespread success and enhanced professional prestige.

Dependence upon adjuncts for suc-

cess in treatment; information derived from the use of scientific gadgets as a substitute for diagnostic acumen; diverting mental energy in the acquirement of the trivial aspects of the specialties for lucrative gain; neglecting osteopathic general practice for the easier, quicker methods of medical or endocrine venoclysis; accepting the shaky, debatable theories of endocrinology in preference to the more stable concept of the lesion; seeking allergic idiosyncrasies rather than skeletal incoordinations; and guessing over the probabilities of vitamin deficiency or imbalance, all tend to scatter the energies of the doctor, divert his attention from the basic principles of his therapy, enhances uncertainty in the results of his therapeutic measure with the end result of osteopathic enervation.

More osteopathy and less of the trimmings are the crying needs. The day of judgment is at hand!

THE PROOF OF THE PUDDING

A gentleman of middle age was indulging in his usual golf game. He was "pivoting" on the right leg. In the "follow through" he wrenched his back low down which caused immediate, as well as subsequent pain, in the lumbo-sacral area. He consulted his family physician, a local surgeon of ability, who put him through the usual course of intravenous medication, mainly salicylates designed to cure rheumatic pains. He was also subjected to the beneficial effects of the therapeutic lights. The result was to grow worse steadily until he was bedfast and in continuous pain.

The question of employing an osteopath met with opposition from the medical advisor but eventually he succumbed to the pressure of insistent demand from the lady members of the family.

The call came to me to see him at his home. At my insistence he was brought to the hospital. He came hobbling in with assistance; every facial

expression, act and word giving evidence of extreme suffering.

The high spots of the case history was taken; a hurried physical examination was made and the trouble located as a lumbo-sacral twist. He was sent to the X-ray department to see if the X-ray would substantiate the findings of the physical examination. While the plates were being developed he came back to the treatment room where a single specific treatment was given. This did not take ten seconds. He returned to the X-ray for another exposure to note what changes, if any in the bony alignment of the pelvic girdle, would be revealed by the skiagraph as a result of the treatment. His first trip to the X-ray was in a wheel chair. He walked down for the second one. The findings from that department follow and are both illuminating and conclusive.

"There is a markedly 'twisted pelvis' with anterior displacement of the right side of the sacrum and flattening of the anterior part of the pelvis towards the right.

"A second examination following treatment for correction of the deformity shows the parts in good position, there being a marked change in position since the former examination.

"Evidence of disease of bone is not found."

The gentleman returned to work the second day after his treatment. He came back a week later for a check up. He has had no further trouble.

As a part of the fee the patient agreed to go tell his physician our method of examination, how we treated him, our check up with the X-ray and his subsequent behavior.

Of course we understand that such methods as we used here are neither applicable nor indicated in the daily grind of the office day. This report may bolster up the courage of some brother whose faith in the lesion and its relief by manipulation is on the wane. Dr. George J. Conley.

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SWIMMER'S EARS

A. B. Crites, D. O. of the College Staff
(From Radio Broadcast Over KMBC.)

Infection of the middle ear is undoubtedly the most prevalent of the serious infections that may affect the swimmer. You, who swim are familiar with the full feeling as if water were in the ears. This full feeling is caused by closure of the Eustachian tube that leads from the upper part of the throat behind the nose up to the Middle ear. It is through this tube that infecting organisms enter the ear. When bacteria reach this area, they quickly proceed to do a big business in small quarters that accounts for the excruciating pain that attends the ear infection and persists until, in some way, drainage can be established.

Would a bathing cap or ear stopper prevent the bacteria in the water from entering the ear?

No, in the first place the infection does not enter the ear by way of the external canal. In the second place it is usually the swimmers own bacteria rather than bacteria from the pool that he forces through the Eustachian tube into his own ear by forcibly snorting and blowing the water from his nose. Diving and swimming under water permits water to enter the nose and as this is continued, an irritation, inflammation, cold in the head or sinus infection, is produced.

To avoid ear infection don't swim when you have a cold, don't blow your nose forcibly but clear the head out in the natural way by snuffing the secretions back and spitting them out the mouth. Man's nose and ears are not constructed for an aquatic life as are some of the lower animals so precautions must be taken.

What are the dangers of middle ear infection, the so-called rising in the ear?

The first thing that comes to mind is infection of the mastoid or mastoiditis, as it is the most serious complication of otitis media. Fortunately it does not usually develop to necessitate operation if the ear is drained quickly and is kept draining freely. The ear that is lanced has a better chance than the one that is permitted to continue aching until it ruptures spontaneously. With present day knowledge and modern methods of treatment mastoiditis requiring operative intervention is much more rare now than formerly. But the thing that always must be borne in mind is

that most deafness in middle life is the result of one or more attacks of middle ear infection in childhood. After the ear infection clears up, the pus stops draining and the hole in the drum closes, there is still a certain amount of debris, fibrous tissue that lines the middle ear covering the three little bones and the mucous membrane located there. This fibrous coating over the three ossicles, the malleus, incus, and stapes interferes with their proper movement, each severe succeeding cold causes more trouble so that after a time they, with the drum or tympanum can no longer properly carry sounds from the outside world into the inner ear. Then the unfortunate individual has a conductive deafness. He may have a perfectly good nerve for hearing and hear well over the 'phone, but because of the impaired middle ear be seriously handicapped.

Conductive deafness is also called catarrhal deafness, is it not?

Yes.

Can anything be done for this type of deafness?

It is this type of deafness that is most amenable to treatment, but it is much easier to prevent than it is to overcome. The child who has frequent head colds is not a good candidate for the life-saving squad, unless the head colds can be eliminated by the removal of infected tonsils and hypertrophied adenoids.

The Eustachian tube drains and ventilates the middle ear, opening with each swallow and yawn and so maintains the same pressure both inside and outside the ear drum. The tube is very subject to the extension of infection from neighboring structures, becoming swollen, inflamed, then closing quite tightly to hold any bacteria that may be forcibly blown through it into the middle ear. So neighboring infections, bad tonsils, hypertrophied adenoids, infected sinuses, the post-nasal dropping and naso-pharyngitis, whatever may be present must be treated to regain the proper functioning of this Eustachian tube, the key to the middle ear. It can readily be seen that the ear is not an isolated organ but is a part of the body and to treat the ear requires the treatment of other parts of the head, indeed the body as a whole.

MOST COMMON PRIMARY LESIONS OF THE FOOT

J. Miller Forcade, D.O.

When one picks up a skeleton of the human foot he is impressed with the size and position of the calcaneus and talus as related to the other bones of the foot. Size does not always indicate importance but I believe in this case it does. To my mind there are no other two bones in the human foot as important as the calcaneus and talus. Certainly they were intended to play a very important part in the function of the foot. Viewed from the standpoint of weight bearing, locomotion, shock absorption or balance they stand out equally prominent. The area and position of the joint surfaces between these two bones show they were intended to stand great stress, particularly perpendicular weight. Their articulations with the scaphoid and cuboid show they are well fitted for moving the weight forward as well as receiving shocks.

It is the talus that receives the body weight direct from the limb and transmits it to the rest of the foot. This bone by means of its cross arm action controls the distribution of the weight on the foot. Normally most of this weight is received by the strong calcaneus which strikes the ground first in walking. Part of this weight is then distributed to the outer anterior part of the foot by means of the cuboid, and part moves forward onto the inner anterior part of the foot by means of the navicular and cuneiforms. As the outer part of the foot contacts the ground and the base of the calcaneus rises more of the weight is tipped inward until the final shove in walking is made from the tip of the great toe.

The calcaneus is sometimes called the rudder of the foot and truly it is. Generally speaking as goes the calcaneus so goes the rest of the foot. If the calcaneus is in correct position the foot is usually strong and functions well. If the calcaneus rotates inward (talus moves postero-lateral on the calcaneus—Dr. Stinson) the foot becomes correspondingly strained, weakened and flattened. If the calcaneus rotates outward (talus moves antero-medial on the calcaneus—Dr. Stinson) the arch is raised abnormally high and the foot is strained accordingly. This lesion along with other factors is the cause of bunions according to Dr. Stinson.

Trouble in the posterior part of the foot is responsible for most symptoms produced in the anterior part of the foot. The primary lesion is usually found between the calcaneus and talus. Treatment applied to the anterior part of the foot is usually not successful for this reason. Most cuboid lesions are probably secondary to lesions of calcaneus. Metatarsal pain and callous formation is usually due to a direct heel-to-toe manner of walking. The normal weight distribution is disturbed and too much weight is thrown directly on the metatarsal heads instead of being rolled across them from the outside of the foot. Short, pointed toed, high heeled shoes play no small part in the production of this condition in many feet: high heels by throwing too much weight forward and focusing it at the metatarsal heads: Short pointed shoes by not allowing the toes to function normally.

Probably the most common cause of lesions between the talus and calcaneus is improper shoes, especially high heels. This probably partially explains why the majority of foot patients are women. High heels throw the whole foot out of balance but they put specific strain on this joint, both lateral and antero-posterior. The articular surface of the calcaneus is approximately two and one-half inches above its surface of contact. The base of contact of the calcaneus, not

counting soft tissue, is about the area of a silver dollar. This joint is constructed to adequately stand the strain (including most emergencies) placed on it by this two and one-half inch lever operating on its normal base but it was never intended to stand the strain placed on it by the modern high heel, a strain probably at least ten times as great as normal. Let us figure a little. The modern dress heel is at least three and one-half inches high, the base of which varies from the size of a dime to the size of a quarter. These dress models are practically always pumps with pointed outflaring toes and are worn too short to keep them from slipping off at the heel. There is no sort of protection to prevent the heel from tipping laterally in the shoe which makes a very unstable base of support to say the least. These heels soon wear off on the inside, usually, which makes bad matters worse. This means that the foot, and especially the talo-calcaneal articulation, must stand the strain of a six inch lever instead of the normal two and one-half inch lever and must do it on a much smaller base than normal and at more than twice its usual anterior-posterior inclination. This excessive strain long continued, weakens the ligaments and the weight drives the talus antero-medial as above described. The short shoe further aids in "humping" the foot upward making an excessive high arch.

Osteopathic lesions in other parts of the body play their part in foot conditions. Lesions of the fibula weaken the ankle joint and predispose to foot conditions. Lesions of the knee, lumbar and innominates should receive proper attention. Errors of locomotion due to short lower extremity, corns, etc. must be considered. Walking on the outside of the foot to protect a sore toe was probably responsible for the trouble in one of our cases in a boy about eight years of age. Systemic conditions and even bad tonsils and other

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foci must not be entirely forgotten. Injuries, especially sprained ankles, is the history in many of our cases.

The technic for its corrections as given by the Chicago Technic Team at Wichita last summer is as follows: The patient lies supine on the table. Operator stands at foot of the table. For inward rotation of the calcaneus (talus postero-lateral on the calcaneus) grasp the calcaneus with the right hand (for the right foot) and raise the foot to a convenient working level. Hold the anterior end of the calcaneus with the right hand on the medial side and "spot" pressure thrust on lateral side of talus, (just below) the inferior margin of the tibia and in front of the fibular malleolus. The thrust is made while some tension is held on the foot and leg.

For outward rotation of the calcaneus (talus antero-medial on the calcaneus) on the left foot: Hold the inferior end of the calcaneus on the lateral side and "spot" pressure thrust on the medial side of talus, just in front of tibial malleolus.

The
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Kansas City College
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LUDWIG'S ANGINA

A CASE HISTORY

K. E. Ross, D.O.

Miss C. N., age 14, female, student; first seen by the writer on May the tenth, at which time she was brought in for diagnosis and treatment on the advice of her dentist. The following history and symptomatology was obtained.

On the second of May the patient had become ill with coryzal symptoms and a slight rise in temperature. The family physician had been consulted and on the basis of the appearance of the oral cavity, a diagnosis of measles was made. No rash appeared, but on the second day of the illness a tooth-ache developed, accompanied by some edema and tenderness of the left submaxillary area. The attending doctor was again summoned and recommended palliative treatment on the assumption that the trouble was an abscessed first molar tooth in the left mandible, complicating the measles. Several days elapsed but the condition became steadily worse. The family physician then sent the patient to the dentist, advising extraction of the offending molar.

Dental examination revealed considerable edema of the floor of the mouth, general oral sepsis, many cavities, evidence of an apical abscess involving the molar in question, and a loose deciduous tooth. The dentist extracted the loose tooth but refused to tamper with the abscessed molar until further medical consultation had been acquired.

On the tenth of May the patient was brought in for examination and at that time the condition was somewhat alarming. The patient's nutritional condition was markedly poor. Dysphagia was so marked that teaspoonful quantities of water were ingested only with difficulty. The left submaxillary region and adjacent neck tissues were greatly swollen and

wooden in consistency as far down as the clavicle. The overlying skin was slightly reddened and tense. The accessory muscles of respiration were active.

Examination of the patient revealed a pulse rate of 120, respiratory rate 20, and temperature 102.6 degrees F. The oral cavity was in markedly poor condition, presenting the appearance of chronic ulcerative stomatitis. Many teeth were carious and the gingival margins pyogenic. No anatomical abnormalities of the mouth floor, mandibles, palatine bones or submental tissues were detected. The salivary ducts were not occluded and the parotid glands uninvolved.

No laboratory facilities being available, other than chemical urinalysis, a blood count was out of the question. Urinalysis, however, indicated nothing of pathological significance other than a positive albumin reaction and indicanuria. The quantity had previously been noted to be diminished and the color somewhat darker than usual.

The gastro-intestinal history was, from a practical standpoint, negative. The chest was examined and some evidence of a previous tubercular infection was elicited. There was evidence of a slight bronchitis, but no signs of active organic pathology were detected at the time.

The gynecological, urinary and previous childhood histories presented nothing of outstanding interest except that a partial, left sided facial paralysis had occurred following a neck injury several years previously. The family history was negative except for a tendency to hypertension and nephritis in both father and mother; the father at present is partially paralyzed as a result of cerebral hemorrhage.

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In view of the above clinical findings, the case was diagnosed as Ludwig's Angina and immediate hospitalization recommended. Circumstances were such, however, that the recommendation could not be accepted and it became necessary to care for the case in the home.

The patient was given grs. 1.5 of phenobarbital, prepared for the incision and, amid a grouping of hysterical relatives and interested neighbors, was placed on the dining room table. Fifteen minutes later ethyl chloride anesthesia was begun. The patient exhibited a mild excitement stage, and as the ether was administered, ceased breathing. Artificial respiration was immediately applied and continued approximately three minutes while the pileous appendages of the aforementioned interested neighbors, elevated somewhat in silent contemplation of the clumsy inadequate blunderings of a certain young osteopath.

The ether was resumed, however, as the patient began breathing and continued until deep surgical anesthesia obtained.

A superficial incision was then made, beginning slightly below the mandibular margin, and behind the antero-inferior insertion of the masseter muscle. It was carried posteriorly to the antero-superior border of the sternocleidomastoideus muscle. The superficial fascia, platysma and deep fascia were divided and the deeper tissues separated by sharp dissection under the guidance of the palpating finger. An abscess cavity was encountered in the angle formed by the superior belly of the omohyoideus and stylohyoideus muscles, slightly below the greater cornua of the hyoid bone. The various muscle bundles were then separated bluntly along the facial planes and drainage channels assured. Exploration revealed no other pus cavitations so the one abscess was packed lightly with sterile gauze and a moist dressing of Oschners solution applied over the wound.

The post operative pulse rate was 100, respiration 22, and axillary temperature 101.6 degrees. There was no evidence of collapse. On May the eleventh, swelling in the mouth floor increased slightly, dyspnea was marked and deglutition impossible. A second incision was then contemplated but ruled out in view of the increased

severity of the previously existing bronchitis, which made anesthesia unadvisable. Osteopathic splenic manipulation, and the lymphatic pump were applied rather vigorously and by the evening of May the eleventh, the patient could ingest small quantities of fluid. Urinalysis was made and the albumen reaction found to be slightly more marked. The color and quantity remained about the same and no other pathologic urinary findings were encountered. Dr. Povlovich's orange-glucose-saline formula was administered by mouth daily thereafter, a minimum limit of one quart daily was enforced.

On the twelfth of May most of the edema of the floor of the mouth had subsided and breathing became much less labored. Expectoration of quite copious quantities of mucopurulent material from the lungs was noted and many varieties of rales were audible over the entire chest. The temperature, pulse and respiration remained unaltered but the lymphatic pump increased the expectoration and added much to the comfort of the patient.

The albumen in the urine cleared up on the thirteenth of May and a general recession of the hectic symptoms began and continued to the termination of the case. Osteopathic treatment, consisting of the lymph pump, splenic manipulation and general relaxation of the entire spinal musculature was employed once daily. The only adjuncts used were the glucose formula mentioned above and protonuclein tablets given four times daily. The gauze drain was removed and replaced daily and a continuous warm Oschners solution dressing was kept constantly over the wound.

The patient left her bed on the tenth day following operation and has gained steadily in strength since that time, the bronchitis cleared nicely and no further complications of any nature developed during the course of the case.

In view of the recent article by Dr. A. B. Crites, in the May issue of the College Journal, little need be said concerning the etiology, pathology, clinical course—or mortality rate of Ludwig's Angina; there is, however, MUCH to be said concerning the efficiency of purely Osteopathic therapeutics where it is most needed and where it works best—at the bedside.

A LITTLE CHILD SHALL LEAD THEM!

"It Is A True, True Story".

From my office in Kansas City came the other day the following note from our registrar, Dr. Leanora B. Johnston:

"Just now, a pretty little girl, seven years old, with black curly hair, came into the office, with a little wooden barrel bank in her hand. She said her bank was full, and that she had been saving her pennies for the hospital fund. She opened the bank, and wanted to count the pennies, so she stacked them up in piles of ten. She had 78 pennies. She wanted to take her bank home, so she could fill it up again for us. Her name is Dorothy Jane Boyer. Both she and her mother are clinic patients."

And so, from the pennies of widows and children is being built the fund that is to assure us of our clinical hospital where the children and the widows can come for the help they need to restore them to health and happiness.

And from our fellow osteopaths the country over is also coming aid for this worthy cause. Not a great number have responded to our plea for help but—SOME have. Maybe your name will appear on the Roll of Honor. Maybe it won't. It will appear only if you help finance this proposition.

Maybe you feel it is our personal concern and no concern of yours. Well, it is if you feel that way about it. The hospital will be a clinical hospital—a teaching hospital. It will, in a degree, considering its size, be an answer to your question: "Where can I enter a hospital and gain the instruction I want?"

This hospital will be devoted to the better instruction of those who would be osteopathic physicians. It will be for the benefit of those osteopathic adherents and boosters who cannot afford to go to a privately owned osteopathic hospital—nor a privately owned medical hospital—and must, per force, go to a medically controlled general hospital and thus be lost to a degree to osteopathy.

And these good people who cannot afford the best in hospital service do not wish to be charity patients in a general hospital. They are willing and anxious to pay within their means.

And we propose to offer them every attention that can be given a patient in the highest priced hospital in the United States at a price they can and will pay if only enough Good Samaritans give of their means to make this possible. "And he gave the Inn-keeper some money and said: 'Whatsoever more thou spendest, I will repay thee'."

With this money you give us, we propose to build a hospital equal, except in size, to any in the land. And it will be self-supporting at a price the worthy poor can pay.

And a little seven-year-old leads the way. She gave us her whole bank full of pennies: And all we ask of you is a few dollars. Can you let this plea go unheeded? Let your answer appear in the next issue of the College Journal.

Clinical Benefactors—Any sum.

Professional Benefactors—\$10.00 to \$30.00.

Lay Benefactors—Any sum.

A. A. Kaiser, Secretary.