12-17-1915

The Pulse, Volume 10, No. 4, 1915

University of Nebraska College of Medicine

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DR. A. A. JOHNSON
Instructor in Clinical Pathology
LABORATORY AIDS IN THE DIAGNOSIS OF SYphilIS.

Those who are giving their best time to the diagnosis and treatment of syphilis believe that to treat the disease most effectively that a diagnosis should be made at the earliest possible date after the infection and that the treatment should be pushed vigorously. It is generally understood that more can be accomplished in one week in the early primary stage than in six months in the secondary or later stages of the disease. Before the discovery of the Treponema pallida by Schaudinn in March, 1903, the diagnosis had to be made by the clinical findings and history and usually the diagnosis was held in question until the secondary symptoms appeared, which is the time when the organisms of the disease are well distributed throughout the various organs of the body. This has been shown by the changes that are found in the spinal fluid and the reactions set up in the small capillaries of the skin. It has been found quite frequently in the secondary stage that there is an increase in the cell count of the spinal fluid.

To be certain of the disease in the early primary stage the organism as described by Schaudinn must be found. There are a few difficulties that are to be encountered in this process. In the first place a good knowledge of the organism must be had. This, as has been described by most writers, has the following characteristics: It is of extreme delicacy, sharp, deep, regular numerous twists. These twists are performed and persist when the organism is at rest as well as when in motion. These points serve to differentiate the pallida from all other organisms except the Spirochaeta pertenius and Spirochaeta microdentum. In stained smears the characteristic windings may be distorted in making the preparations and in this way the more marked characteristics be lost, but the following points are usually decisive: The difficulty of staining, the very small size with a length of 4-14 micra and a width of ¼ micra and 6-14 twists. Rarely longer individuals are seen up to 26 micra with 10-26 twists. Some individuals, too, almost always have the typically and closely set windings. In structure the organism has the appearance of a single spirally wound wire. It is highly motile and the motility is of three kinds, rotary, forwards and backwards and lateral flexibility.

The chancreoid or the (Duerrey infection) can be differentiated from the chancre or the (Schaudinn infection) by the finding of the above described specific organism in the lesion. The various methods for carrying out this procedure are as follows:

First and of the most importance is to find the organism by the dark field illuminator. By this method the organism can be studied both as to its morphology and its motility.
Second. Another dark field method where the organism is not stained but appears as a colorless spiral on a black background is the Burri's India ink method. The clear serum can be obtained from the suspected lesion and a drop mixed with a drop of the ink and this evenly spread on a glass slide. The organism should then be searched for by the oil immersion lens, and if objects are found with the characteristic morphology your diagnosis should be confirmed by other methods. If the organism cannot be found by this method other methods usually fail. Some laboratory workers claim that there are objects in the ink preparations that are apt to be taken for the spirochaetes. This can be avoided by using a good preparation of ink.

Third. Levaditti's silver nitrate method.

Fourth. The various blood stains, Wright's, Giemsa's and Hastings'.

Fifth. By animal inoculation. Testicle of rabbit.

If the organism is not found by the first examination, successive examinations should be made, and if not found the patient should be watched and a Wassermann test should be made before a final decision is reached. In doubtful lesions the finding of the specific organism settles the matter, but not so in the negative case.

When the spirochaetes are found in the lesions the Wassermann test is often negative or questionably positive and is therefore of little value in such cases. In the records of most laboratories the test is positive in about 70 per cent of cases.

If there was made in each case a thorough search of the lesion for the Treponema pallida and if not found to wait and watch and to have the Wassermann test performed on the blood at the earliest possible time it would avoid many disagreeable treatments and much worry in later years. There are many setbacks to this method of treating the disease. The patient usually or often consults many before he consults the man who will make the proper examination, and usually the lesion has been treated by caustics and calomel powder many times. In this manner the organisms are destroyed in the superficial portions of the lesion and the diagnosis made much more difficult.

If the lesion is treated surgically, the specimen can be examined histologically and if the organisms are not found the peri-vascular changes will give evidence of the disease. This method has its advantages because it removes the large number of organisms in the local lesion.

In the secondary stage there is also the chance to find the organism in the mucous patch or the condylomata, also the Wassermann test is here the most valuable. The diagnosis of lesions in the mouth or on the lips is most difficult because of the presence of the other organisms; Spirochaeta dentium, which has closely set twists, but these are not so regular as those found in the Treponema pallida. The refringens are coarser and can easily be identified. In this stage about 75 per cent give a positive Wassermann test.

The tertiary congenital and late stages of the disease can be diag-
nosed by the Wassermann, assisted by the provocative reaction, the fucnin test as devised by Noguchi and the lumbar puncture.

In these cases the Wassermann test is positive in a high percentage of cases where the disease is active and progressing. Such cases are aneurisms, eye conditions, nose lesions, and lesions of the vocal cords, tonsils, bones and paresis.

Where the Wassermann is positive in tertiary lesions a better prognosis can be given, as here the disease is active and progressing, and by active and vigorous treatment the disease can be checked. In tabes, where the disease is active, there is a positive Wassermann test.

The lumbar puncture should be made in every case where nervous symptoms suggest the diagnosis of hysteria or neurasthenia. The fluid in positive cases usually is under pressure and has an increased cell count of the leucocytes.

If there is an increase in the cell count a diagnosis of meningitis can be made and then the causative factor determined by the type of the cells and chemical and biological tests.

In order of their importance the cell count and the Wassermann test give us the most information.

The test on the spinal fluid should be performed by using increasing amount of the fluid in the tests, as 1 cc., 2 cc., 4 cc., 8cc. In paresis there will be a high cell count and the Wassermann test will be positive in all dilutions, where in tabes there is only fixation of complement in the lower dilutions, and the cell count is not so high as in paresis.

Lange's gold chloride test has been used in this laboratory, but it has given no information that cannot be gained by the cell count and the Wassermann test.

The Noguchi and the Nonne test on the spinal fluid give but little evidence as to the cause of the inflamed meninges.

Syphilis is one of the commonest diseases known and it should suggest to every physician that it is found in all classes and races. In many instances where the disease is detected and the specific treatment applied there is a remarkable improvement in cases that had previously been considered hopeless.

In our series of post mortem examinations, where the diagnosis had been made by laboratory methods, there has not been a single conflict in the laboratory and the post mortem reports. This series includes the repeated examinations on cases of brain tumors, aneurisms and meningitis.

A. A. JOHNSON.

TURNABOUT.

The doctor entered the patient's room in the morning, and according to habit, read the chart the first thing. He was a little surprised to read:

"2 A. M. Patient very restless, nurse sleeping quietly."—Collier's Weekly.
Dr. A. P. Overgard, '00, of Omaha has an article on X-Ray Findings in Cancer of the Stomach in the November Western Medical Review.

Dr. F. J. Kotlar, '14, has formed a partnership with Dr. W. S. Evans of Columbus, Neb.

Dr. J. M. Patton and wife recently spent three weeks in the east on a well earned vacation.

Dr. A. C. Stokes, '99, will go east soon to attend the Southern Surgery Association meeting, which meets in Cincinnati, December 14 to 16.

Dr. W. P. Wherry, '03, made a trip to Chicago on business in December.

Dr. F. N. Jensen, '03, of Newman Grove, Neb., was married the past summer to Miss Minnie Mack of Omaha.
REPORT OF ALUMNI ASSOCIATION OF THE UNIVERSITY 
OF NEBRASKA COLLEGE OF MEDICINE.

ANNUAL BUSINESS MEETING.
University Club, October 21, 1915.

Society called to order by President Patton. Minutes of meeting of October 14, 1914, read and approved. Chairman LeMar of the Resolutions Committee reported as follows:

IN MEMORIUM.

Whereas, The Great Physician has removed from this life Dr Smith W. Bellinger, Dr. Dan. F. Lee, Dr. David Beatty, Dr. H. C. Wheeler, and

Whereas, The passing of these from our Alumni deprives us of four well beloved co-workers; therefore, be it

Resolved, By the Alumni Association of the College of Medicine of the University of Nebraska in annual session assembled that, while we humbly bow in submission to the wisdom of God, we nevertheless are grieved by the departure of these honorable men, and be it further

Resolved, That a copy of these resolutions be sent to each of the bereaved families, and that a copy be spread upon the minutes of this meeting.

Be it resolved, that the Alumni Association of the University of Nebraska College of Medicine do hereby heartily endorse the action of the Chancellor and of the Board of Regents for their appreciation of the quality of our graduate body in their selections from our members of Dr. I. S. Cutter and Dr. R. A. Lyman as Dean and Associate Dean, respectively, of the College of Medicine. The Alumni Association welcomes all things indicative of progress in our Alma Mater, and stands ready at all times to aid in every way for the best interests of our school. Be it further
Resolved, That this resolution be placed upon our minutes and a copy thereof be sent to the Chancellor and Board of Regents.

(Signed)

C. L. LEMAR,  
A. P. OVERGAARD,  
D. G. GRIFFITHS,  
Committee.

Chairman McArthur, committee on auditing and finances, reported the committee had audited the books of Secretary-Treasurer and found same correct.

Chairman Stokes, committee on by-laws, had no report.

Report of Secretary-Treasurer was read and placed upon the file. The following is the report:

**Final Report of Secretary for the Year Ending October 21, 1915.**

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Total ....................................................... $603.45

Disbursements.

Cash on hand October 21, 1915 ........................................ $603.45

Typewriter ribbon .................................. $ 3.00
Circular letter, stamps, Feb. 2 .................. 5.20
Circular letter, stamps, Feb. 13 .............. 5.20
Circular letter, stamps, Feb. 19 .............. 5.20
Pre-Medical Society letter ...................... 7.00
Envelopes (proceedings) ......................... 5.25
Stenographer ........................................... 10.00
Stamps, circular Alumni letter ................. 9.50
Addressograph and plates ....................... 70.00
Postage (proceedings) ............................ 31.20
Postage (sixth annual programs) ............. 9.85
Printing proceedings ............................ 295.00
General printing .................................... 23.50
Salary ................................................... 50.00
Postage, second sixth annual programs ...... 9.85
General postage and exchange ................. 8.65 $548.40

Total cash on hand .................................. $55.05

Audited and approved October 21, 1915.

H. J. McArdur,
B. W. Christie,
E. L. Bridges.

REPORT OF FINANCIAL SECRETARY.

Receipts.

W. O. Bridges ............................................. $ 25.00
B. B. Davis ................................................. 25.00
H. Gifford .................................................... 25.00
A. F. Jonas .................................................... 25.00
F. S. Owen ..................................................... 25.00
L. Crummer .................................................... 20.00
P. Findley ..................................................... 20.00
J. P. Lord ...................................................... 20.00
A. C. Stokes ................................................... 20.00
J. E. Summers .................................................. 20.00
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$457.50

Expenditures.

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<td>Orpheum</td>
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$215.60

Total collected .............. $457.50
Total expended .................................. 215.60

Balance ........................................... $241.90

Chairman Knod of the nominating committee reported the committee had selected the following as officers for 1915: President, A. E. Lane, Laramie, Wyo.; First Vice President, W. H. Taylor, Omaha; Second Vice President, Geo. Alliband, Elliott, Ia.

New Business.

F. W. Scott moved that votes of thanks be extended to I. S. Cutter for his magnificent fight in securing university hospital.

M. B. Baker moved that the dues be reduced to $1.00 and the "proceedings" be discontinued.

On motion as amendment the dues be same and "proceedings" be discontinued and proceedings of sixth annual week be published monthly in the Pulse and a copy sent to all paying dues.

On motion association adjourned.

ROY A. DODGE, Secretary-Treasurer.

NU SIGMA NU NOTES.

The annual banquet was held during alumni week of the past month. About seventy-five were present and an enjoyable time was reported by all.

Dr. Pratt recently made a trip east in connection with a very interesting case of a child who had in some manner gotten the metal cap of a lead pencil into her lungs. The case was taken to Dr. Jackson of Philadelphia, a specialist on lung surgery.

During Thanksgiving vacation a house dance was given by the men who were in town. Among the good things to come a dance is to be given at the Prairie Park Club on Friday, December 10, and a number of out-of-town guests are expected.

A serious epidemic of tonsilitis has spread among the members of the chapter, the victims so far being Losey, Safarik, Steenberg, Bailey, Krahaulick and Oden. The source of the infection has not been discovered as yet.

A Victrola recently installed has proven very useful for house dances and is a source of enjoyment for the men at the house.

PHI RHO SIGMA NOTES.

A house dance, enjoyable in every respect, was given December 2. Chocolate and accessories were served by "Dr. Wheatly," and the music was the best ever.

"Amoeba" Cultra is now on the sick list with influenza.
“Dutch” Newbecker was also on the sick list, but got well rather than take any more salicylate, a routine very much in vogue among some of the members of the junior class. As a cure-all for coryza, influenza, backache and liver trouble it is said to excel Pierce’s Golden Medical Discovery and Father John’s medicine is a mere bag of shells in comparison.

“Salicylate” Sherwood says Sh! Sh! no longer, for the alumni have presented the chapter with a long rug for the hallway on the second floor. By wearing rubber heels and going on intermediate it will now be possible to pussy foot it to Thompson’s room for cake without being tubbed or hounded by those who wish to study. The alumni deserve a vote of thanks.

Dr. Wherry and Dr. Keegan were guests at dinner the other evening.

Meyers was also ill with an attack of pseudo influenza. (This item would not have been mentioned had it not been for a cigar given to the writer of these notes).

Plans are being made to have a Christmas tree before going home for the holidays. No doubt “Kris” has some surprises in store. However, our parting advice is “stick to your salicylates,” “shove back your ears,” and “don’t get hung in your own holly wreath or cooked in your own plum pudding as did old Scrooge.”

PRE MEDICAL.

CHEM. LAB.—SCENE I.

Ford—“Dutch Weymuller is going railroading because he makes so many breaks (brakes).”

Weymuller—“Did someone say the pun is the lowest form of wit?”

Chemistry Rules Devised and Executed by Dr. Frankforter.

1. There is no such phrase as “clean enough.”
2. Never scrub off tomorrow what you can wash off today.
3. Towels are used for drying and not for rubbing off dirt.
4. Your neighbors’ eyes were made for targets and their noses for fume receptacles.
5. Weights and hot crucibles should not be held in the fingers.
6. Jottings on loose papers are useful—if you can find them.
7. An unrecorded experiment was never begun.
8. Balances were meant for slop jars.
9. Two hours is usually ample time to make a weighing.
10. If you desire to weigh yourself or other live stock use the finest balances obtainable.
11. Much noise is conducive to good lab. work. Whistle, talk, laugh or if unable to do any of these, singing might be attempted. “Music hath charms.”
12. Work like h—and be happy.
DISORDERS OF SPEECH.

Speech is an arbitrary code of signals, vocal or written. Language is any means of communication between mind and mind. Language contains all we say of speech plus an exchange of ideas by signs. Two individuals, each ignorant of the spoken or written language of the other, can certainly communicate with each other by gestures, and by the simple primitive expressions of emotion, joy, surprise, anger and other natural acts. Regarded as a physiological study the faculty of speech consists not alone in uttering words, but in the power of word making. This means that words must be acquired and held in storage, for use when needed. That process we call education. The two principal avenues through which we acquire knowledge are the ear and the eye. The former conveys sounds. The latter conveys form, color and texture. All these impressions are conveyed to centers in the brain. Speech then is disturbed by anything that impairs our faculty to receive impressions, or possessing them, express ideas. The brain is the seat of the mind, and like every other part of the body is subject to disease. A person afflicted with a lesion in one of the speech centers in the brain, and who is conscious of his infirmity, has aphasia. These speech centers are located in the cortex, they are connected with each other, and with the sub-cortical tissue, by fibers. Pathology in the auditory track, or in its cortical center, at the upper surface of the left temporal lobe—Broca's convolution—or in the visual path from the eye through the optic nerve, chiasm, and fibers on to the primary visual centers of the angular gyrus in the occipital lobe that impairs reception, is known as sensory aphasia. Conversely when the faculty to receive impressions is normal, but ability to express ideas, is impaired we call that disorder, motor aphasia. If we fix those two divisions of speech disorder in our mind, we have simplified the subject of aphasias due to organic lesions. This does not include faulty articulations predicated on diphtheritic or other peripheral palsies in nerves supplying the muscles of phonation, nor does it include congenital mutism, idiocy and acquired dementias from intellectual deterioration in persons afflicted with mental states known as melancholia and mania. The former is obviously not connected with the intelligence centers, and the latter is assuredly a cellular lesion in the highest intellectual centers. The clinical history affords adequate evidence for the differential diagnosis between a speech disorder due to focal lesions in the cortex, dementia without circulatory changes, and imperfect articulation because of peripheral nerve lesions. Webster defines aphasia as "a loss of the power of speech or of the appropriate use of words, the vocal organs remaining intact, and the intelligence being preserved." The aphasic then is a person who is afflicted with a lesion in one of the speech centers, and yet is perfectly conscious of his infirmity. The reason speech disorders are so confusing and difficult to understand is principally because we have not agreed upon a uniform and simple analysis of the subject. We believe the brain is the seat of the mind. Speaking then is an expression of intelligence made possible by brain function. In order to speak correctly the brain must receive impres-
sions and it must express ideas. It is first acted upon, then in response to a stimulus it acts. The act of giving out what has been acquired is designated motor and of receiving, sensory. Motor aphasia means faulty expression. Sensory aphasia means faulty perception. Around these two divisions we can arrange types of aphasia and all words relating to speech imperfections. Disorders of speech due to focal lesions of the cerebrum are distinguished as aphasic, while any disturbance of articulation due to a lesion of the mechanism of the nerves, and governing muscles of speech are not aphasics. They are disorders of phonation sequential to cleft palate, hair lip, absence of teeth, no nasal septum, lack of cerebral development—idiot or cretin—or are secondary to multiple sclerosis, paresis, brain tumor, chorea (major), myasthenia (gravis), paralysis agitans, myxedema and meningitis. The common varieties we hear are scanning, stuttering, stammering, slurring and bulbar. The aphonia we often see where the integrity of the larynx, and every part of the speech mechanism is intact, and no impairment of the ear and eye apparatus for receiving and expressing ideas, is properly designated, hysterical. We cannot explain hysteria, neither can we analyze the mental process through which suggestion becomes of therapeutic value in the relief of some morbid mental states.

JOSEPH M. AIKIN.

LINCOLN NEWS NOTES.

The Premedic society enjoyed the evening of December 9, spent at the Orthopedic hospital, where they were the guests of Dr. Orr, who provided a very appetizing dinner and then entertained the guests with an illustrated lecture and a tour of the hospital. About eighty students were present to enjoy the evening.

THE ABSENT-MINDED SENIORS.

Scene I.—Seniors all busily studying (reason, two exams the following two hours). Time, A. M. Place, red brick house.

Scene II.—A doctor giving a clinical demonstration, a notable absence of students (Seniors). Doctor goes to telephone, talks, and then turns away with a worried look.

Scene III.—Place, same as in first scene, time also A. M., but a few minutes later. Seniors still studying. Telephone bell rings. German student answers the call. Conversation:

German Youth—“Hello.”
Inquiring Voice—“Where all of the Seniors?”
German Youth—“Why! Why!—I, I (pause) I guess they have all gone to the clinic, doctor. I am just starting. Goodbye.”

Scene IV.—Place, side-hill back of red brick house, Seniors (in stooped positions stealing stealthily toward summit of hill) books under arms, frightened look upon faces, all clamber aboard car at Fortieth and Farnam.

Scene V.—Place, the clinical demonstration room as in Scene II. Seniors present in force, German student on front row. Doctor looks much happier than in Scene II.
INTR A ABDOMINAL HERNIA, WITH REPORT OF CASE.

Treitz was the first to describe internal hernias and in 1857 he called attention to the various fossae within the abdomen and explained the formation of these hernias.

Johnson in his surgical diagnosis says various forms of internal hernias are rare causes of bowel obstruction and I find no cases in which the diagnosis was made during life before operation.

Barnard’s reports show that out of 669 cases of bowel obstruction at the London Hospital, 13 were due to internal hernia.

For study, we divide these hernias according to their anatomical location into pro-peritoneal, diaphragmatic, retro-peritoneal, hernia through the foramen of Winslow.

I have not included the first two in this paper as pro-peritoneal hernias are not intra abdominal, and diaphragmatic hernias are partly extra abdominal and are so numerous as to hardly merit our discussion. In 1899, 433 cases had been reported; in 1908 only 10 had been diagnosed before operation or autopsy; at present the X-ray gives the diagnosis in the majority of cases.

Various fossae have been described and altogether 17 have been described, but a number of these are unimportant.

The following regions are the seat of fossae sufficiently frequent to demand attention:

- Intersigmoid .................. one fossae
- Pericaecal ........................ five fossae
- Duodenojejunal area ............... five
- Foramen of Winslow ................ one
- Pre-vesicle area .................... one

The chief symptoms in most cases have been those of strangulation or obstruction, a few being discovered at autopsy or during an operation for some other condition.

About the only difference in the different varieties is the location of the swelling or tumor mass.

DESCRIPTION OF FO SSAE.

Intersigmoid Fossa

Intersigmoid fossa is a recess formed along the left leaf of the mesosigmoid. One border of the recess is formed by the sigmoid artery. This fossa is seldom seen in adults and hernia is very rare.

Frammes Fossa.

Framme describes a hernia into the space in front of the bladder, which almost corresponds to space of Retzius, into which a peritoneal pouch was pushed.

Pericaecal Fossae (4 in number).

1. Ileo Colic—At junction of ileum and colon where mesentery changes to peritoneum of colon, also called superior ileo caecal.
2. Inferior Ileo Caecal—Beneath the ileum and bounded by mesoappendix and the anterior fold of peritoneum. Ileo appendicular looks to the left and downward.
3. Retro Colic Fossa—Behind caecum and looks downward. Occasionally double. Also called sub-cecal. The colon in its descent is not firmly attached to the posterior wall of the abdomen and these folds are the result.

4. Fossa Iliacosubfosaialis or fossa of Biesiadecki lies in the middle of the right iliac fossa looking upward, anterior wall is formed by a fold of the iliac fascia.

5. Short describes a fossa behind the caecum, but facing the right side. This was the seat of a hernia.

**Duodenal Fossae (1).**

1. Duodenal Fossae (May Coexist)—Inferior non-vascular as a rule; if vascular, fossa of Treitz. Superior always vascular.

2. Duodenal Jejunal (never with the above)—Simple and double (always vascular).

Moynihon describes 9 fossae. Only 5 are important.

1. Superior duodenal fossa found in 40 to 50 per cent cases, discovered by Broesike. Occupies the upper horn of fossa of Treitz (para jejunal).

2. Inferior duodenal fossa, most frequent, 70 to 75 per cent. On left side of ascending portion of duodenum. Orifice looks upward opposite that of Sup. Duod. Fossa.

3. Para duodenal fossa (Landzert) to left and at some distance from ascending limb of duodenum. Caused by the inferior mesenteric vein raising a fold, orifice looks down and to the right. Is bounded by parietal peritoneum covering the psoas, the renal vessels, the ureter and a portion of the left kidney.

**Duodenal Fossae (2).**

4. Mesenterica parietal fossa usually in first part of the mesojejunum, behind the superior mesenteric artery and below the duodenum. Moynihon found this fossa, three times in adults and in seventeen embryos of less than 5 or 6 months it was present in 6. This is also known as Waldeyers fossa.

5. Meso colic fossa, formed by a fold containing the ascending branch of the left colic artery, extends between the layers of the transverse mesocolon toward the spleen.

Moynihon thinks these fossae are the result of fusion folds of the peritoneum.

**Author's Case.**

Patient, female; age, 25; family history, negative; personal history up to eight years ago, negative. At this time she began to be constipated and had attacks of colic, more marked on taking a cathartic. Constipation became more severe and attacks of pain more frequent and prolonged, for several years has required morphine for pain. Pain started in the epigastrium and soon spread through the entire abdomen, then she would become distended. After having some morphine and a cathartic her bowels would move in a day or two and she would be relieved.

I saw the patient while having an attack and expected to operate
upon her, but she was given some castor oil and the trouble subsided, so I held her for further observation. Examination in the interval disclosed very little. Patient was under nourished and appeared to be suffering from some toxaemia. Pelvic examination disclosed some increased resistance on the left side, otherwise normal. In a few weeks she had another attack of pain, vomiting and distension. The distension was to the left of the median line and below the umbilicus. It was oval in contour and had the appearance of an ovarian cyst, but was resonant on percussion. No definite diagnosis seemed possible, so an exploratory incision was advised.

**Operation.**

Supra pubic median incision.

On reaching the peritoneum there was an abnormal opaque appearing mass just beneath it. The peritoneum was opened very cautiously, as it was very uncertain what was beneath.

As soon as the abdomen was open a whitish mass appeared and there was a considerable quantity of serum free in the cavity.

The mass appeared to be a large ovarian cyst, but in the thinner areas intestine could be seen shining through and tracing the wall of the mass it passed up toward the under surface of the mesocolon.

On lifting the mass to one side it was found that the small intestine had disappeared and only the colon and stomach could be seen.

All of the small intestine with the exception of about two inches at each end was in the sac.

The neck of the sac reached down almost to the caecum and was large enough to admit two fingers, so the obstruction was not due to pressure at that point.

On attempting to withdraw the coils of intestine, they were found to be densely adhered and reduction was impossible.

On careful inspection of the sac, it was found that there were no large vessels near the neck and it was decided to open it up.

The sac was split up the anterior surface almost up to the meso colon, the adhesions broken up as much as possible and where adhesions to the sac were too dense a portion of the sac was left attached to the gut.

All kinks and obstructive bands were relieved and as much as possible of the sac was cut away.

Abdomen closed without drainage. Patient was returned to bed in good condition and made a rather uneventful convalescence, with the exception of passing a dark bloody stool the third day. As this was unaccompanied by any other unfavorable symptoms, it was thought to have been due to haemorrhage during the operation rather than an infarct or vascular injury.

The attacks of pain have not recurred, she eats well, complexion has cleared a great deal and now four weeks after operation she requires no cathartic at all.

**Comments.**

The case reported has a few points of special interest:

First, it is the only one recorded in which the intestine was firmly
adhered to sac and in which the obstruction was due to adhesions and not to strangulation.

Second, it occurred in a non-vascular fossa, thus permitting more extensive cutting than is usually possible.

Third, the patient recovered after very extensive and severe manipulation.

Summary.

Up to date, I find 163 cases of intra abdominal hernia reported. The mortality has been a little over 50 per cent in all varieties.

A correct diagnosis has been made in one case only and suspected in another.

Symptoms are those of bowel obstructions as a rule and diagnosis as to exact condition is almost impossible.

Treatment—Operation is indicated at once. The only contraindication being a moribund patient.

The technique is apt to be difficult as some of these fossae are bounded by important vessels.

The treatment of the condition has varied, dilatation of ring, puncture of intestines to relieve pressure, and then reduction of the hernia, suture of the neck of sac, excision of sac, splitting of sac with partial excision.

As a rule if the strangulation can be relieved it is best to leave the neck of the sac open or pack it with gauze for a few days, as any attempt at closure of sac may be a dangerous proceeding.

C. R. KENNEDY.

ADDITIONS TO THE LIBRARY.

This school year the library is taking on the aspects of a real true library and, although our reading room is not as crowded as the reading room of the main library in Lincoln, nevertheless there are many times during the day when classes are not in session that we are a very busy place.

The doctors in the city and also out in the state are beginning to realize that we have some very valuable books and are very glad to give them a bibliography or the material itself, on any subject in which they are interested. If we do not have the books desired the John Crerar Library of Chicago is very willing to make us two weeks loans. Since May 1 we have added to our library over five hundred fifty books. With a few exceptions of gifts these have been bound periodicals and recently published books. Both the Murphy and Mayo Clinics are now on our shelves; also the Boston Medical and Surgical Journal complete for the last fifteen years, with a few volumes of the earlier years missing. We have just catalogued one of the most extensive works on Anesthesia by Gwathmey, several new text books in Anatomy and Chemistry, Lucini's three volume work on Physiology, the 1914 edition of McKenzie on the Heart and the 1915 edition of Lewis's Lectures on the Heart and all of the 1915 Practical Medicine Series.
The complete set of Archives of Pediatrics has just been received and the current numbers of several new magazines subscribed for, viz: Biochemical Journal, Journal of Laboratory and Clinical Medicine, Frankfurter Zeitschrift fur Pathologie. Only the doctor working on an extensive bibliography or the librarian can realize the amount of money and labor it will take to make our library what it ought to be to keep pace with the other well equipped and progressive departments, but we also are the ones who realize what a splendid nucleus we have around which to grow into the best medical library in the middle west.

HALLIE WILSON, Librarian.

EASTERN EYE DISPENSARIES.

I have been asked to give a short report of the conclusions I have been able to form from a recent visit to a few of the ophthalmological clinics of the east.

Although the purpose of my visit had more to do with the didactic phase of ophthalmological teaching, I had the privilege of visiting the clinics or consulting the head of the clinical staff in ophthalmology in Harvard, Cornell, Columbia, Bellevue, Albany, Jefferson, Pennsylvania, Medico-Chi., Johns Hopkins, University of Chicago and Northwestern.

Excellent clinical courses are given in all of these institutions, but there has apparently been no attempt at standardization. In some institutions little importance is given to operative clinics; in one instance the undergraduates only having one period in the operating room, and that not obligatory. As a rule sections of fourth year students were given an hour of operative clinic a week during a part of all of the year. One department head supplements his clinical operative work by a demonstration course on animal eyes, in order that each student may become familiar with the resistance of the ocular structures, as well as to familiarize himself with the use of the instruments and appropriate technique.

With one or two exceptions little attention was given to clinical instruction in refraction, the theory being that the student gets little if any benefit in the short time allowed for the work. This is disputed by the clinics where systematic courses in refraction are given, as they are able to give the student the principles of the work in which he may later perfect himself if he sees fit.

External disease of the eye are taught in excellent dispensaries, some of the schools having separate buildings devoted to this work. The dispensaries were as a rule well equipped and organized for maximum efficiency for both patient and student. Classes were divided into sections of from four to ten men, who were required to spend from twenty to forty-five hours in the dispensary. In some instances part of this time was devoted to clinical lecturing, but as a rule this time was spent with the patients, there being a sufficient number of clinical assistants to guide the students in every phase of the work. In no instance did I find undergraduate students allowed to do major ophthalmic surgery; but as a rule these operations were carefully demon-
strated to small sections, at which time instructions were given as to technique and management of the case. Marked emphasis was placed on instruction in ophthalmoscopic diagnosis in practically all clinics visited. In some instances fully half of the allotted time was given to this phase of the work. Patients were examined by the students in the dark room, after which the findings were checked by the instructor, errors in technique corrected and cases of special interest demonstrated before the section. Errors in muscle balance, defects in visual and color fields, intra-ocular tension, etc., were given careful attention in the dispensary.

Two things stand out prominently: the careful individual instruction in the details of clinical diagnosis in the treatment of the external diseases of the eye, and the practical training in ophthalmoscopic examination.

JAS. M. PATTON, Omaha.

Dr. Hyde gave a paper before the University Faculty Medical Club the evening of December 7 on "Arthritis Deformans," and all present found his subject of the deepest interest. The rendering of the paper was followed by a discussion of the subject, which lasted more than an hour, and was participated in by all.

LINCOLN ZOOLOGY LAB.

Bradberry to Class—"Cestode technique must be handed in after finishing Nematode."

Thompson—"Will we have lab. Christmas day?"

THE PATIENT'S OWN DIAGNOSIS.

The physicians were consulting beside the bed of a man supposed to have appendicitis.

"No," said one of them decisively, "I think we should wait until he gets stronger before operating."

The other doctor opened his mouth to speak, but the patient beat him to it.

"What do you take me for?" he asked feebly. "A cheese?"
THE MEDICINAL PLANT GARDEN OF THE COLLEGE OF PHAR- 
MACY OF THE UNIVERSITY OF NEBRASKA.

In recent years unusual attention has been called to the cultivation 
of medicinal plants in America. This is due in part to the fact that 
some of the drug plants, the supply of which was supposed to be inex­haustible, are rapidly disappearing from the market. With this short­
age there has, of course, been a corresponding increase in the price. 
Golden seal is an excellent example. It is native to the moist, forested, 
mountainous regions of Kentucky and Tennessee and since it is har­vested by people ignorant of the conservation of the young plants it 
has become almost extinct. The price of the root has, in a decade, 
advanced from a few cents to several dollars per pound.

Drug plants have been gathered the world over from their native 
sources by the cheapest labor, which means the most ignorant type of 
people. No care is taken in selecting, in breeding, in curing or in 
improving methods of handling native plants. In obtaining and mar­keting drug plants two ideas have been uppermost, namely, "cheap­ness of production" and "shrewdness in adulteration." English and 
continental growers have been pioneers in taking steps to improve by 
cultivation certain medicinal plants. For example, with digitalis they 
have been able to produce by breeding and selection, a leaf of very 
superior quality which demands a high price on the American market.

Finally the growing of drug plants has been brought into the lime­light by extravagant and unwarranted statements made through the 
press and otherwise that fortunes are to be made in the growing of 
drug plants. There are no drug plants that grow like weeds, can be 
cut like hay and sell for one thousand dollars a ton, although the root 
of Hydrastis canadensis is now worth approximately ten dollars a 
pound. There are few farmers who would have the patience to nurse 
the tender plants in some moist shady spot for seven long years before 
a single plant could be uprooted. To one whose interest is commercial 
the raising of corn, wheat and alfalfa is more interesting and certainly 
more profitable.

In our own country the Department of Agriculture, through the 
Bureau of Plant Industry, has been engaged in the growth of medicinal 
plants for about twelve years. Four experimental stations are main­tained by the department. They are located at Arlington, Va., Tim­monsville, S. C., Madison, Wis., and Orange City, Fla. At these various 
stations attention is paid to the growth of plants adapted to the cli­mate of that particular station. At the Arlington station, which is the 
largest, investigation is carried on for the purpose of increasing the 
quality of the plants through selection and breeding. At Timmons­ville experiments are being conducted with Cannabis indica to de­termine whether the American grown plant is as active as the one 
grown in India. Cascara sagrada, which is threatened with extermina­tion in the United States, is also being cultivated here, and special 
attention is being given to the various varieties of capsicum. At 
Orange City attention is given especial to the volatile oil producing
plants, and at present they have twenty acres of camphor trees under cultivation. At Madison the work is carried on in co-operation with the Department of Pharmacy of the University of Wisconsin. Special attention is there given to the study of Hydrastis, Ergeron, Wormwood, Coriander and the Mints.

In passing it would not be fair not to mention the excellent work being done by several large private concerns in this country. Especially worthy of mention are the firms of Johnson & Johnson, Eli Lilly and H. K. Mulford, and some others. These firms have spent thousands of dollars in growing and improving the quality of certain drug plants, especially Belladonna and Digitalis. Among the colleges of pharmacy that are doing valuable work along this line are the Universities of Minnesota, Wisconsin, Michigan and the Philadelphia College of Pharmacy, all of which deserve special mention.

The drug plant garden of our own College of Pharmacy is an educational garden. The object of this garden is to be of service in teaching and to determine what drug plants can be grown successfully under our climatic conditions and to work out the facts that will improve the medicinal value of those plants. Approximately one acre of ground is under cultivation and one hundred and twenty-five species of drug plants are growing. The season just past, on account of the abundance of moisture, has been an exceptionally good one. The plants showing a remarkable growth this year are Belladonna, Digitalis, Stramonium, the official Rhubarb, the Docks, Fennel, Lavender, Camomile, Calendula, Lobelia, Male Fern, Sanguinaria, Convallaria, Apocynum, Orris, the Opium poppy, Witch Hazel, Pomegranate, Phytolacca, Juniper, Boneset, Thyme, Aconite, Valerian, Horehound and the Mints. In the green house are growing about twenty-five species of tropic medicinal plants, some of the more important ones being Coca, Camphor, Cinnamon, Gelsemium, Aloes, Physostigma, Ginger, Cardamom, Hematoxylon, Tea, Coffee, Arrowroot, Tolu balsam tree and Abies. One of the interesting sights at present is a tea plant in full bloom and a coca plant bearing ripe berries.

It is a little early to discuss the value of the present crop physiologically. The crude drugs are now being milled and assayed and thus far it has been found that tincture of Belladonna leaves made from this crop contains about 90 per cent of the amount of alkaloid required by the Pharmacopeia, while the tincture of Digitalis made from the leaves of one year old plants is at least double the strength of the standardized tincture placed upon the market by Parke Davis & Co. When the assays are complete a full report of the alkaloidal content will be published.

In the growth of drug plants there are great opportunities for exact scientific study of the methods that will increase the physiologically active principles. This work is, however, a work of service and great financial returns cannot be expected. It dampens the ardor of most cultural enthusiasts when they learn that the first few pounds of Belladonna leaves that were raised by Johnson & Johnson in California
cost that firm the sum of $3,500 and the first few pounds of Digitalis leaves grown by Eli Lilly Company cost that firm $1,000.

The University of Nebraska College of Pharmacy will put forth every effort to develop this work, which seems to be of the greatest importance in giving us a dependable supply of reliable drug plants for future consumption.

DEAN RUFUS A. LYMAN.

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SENIOR CLASS NOTES.

Dr. Hollister has diagnosed a very usual disease in our classmate, Shepherd. It seems that “Shep” is suffering from an acute attack of "tactis thecodritis."

Dr. Bridges—“Here we have a patient who has a full habit.”

Dr. Crumrner—“I’m inclined to pluck the man who does not bring his own stethoscope to my clinic.” Whereupon Leonard whipped forth his combination Ford-Bowles and “plinked it loudly.”

Dr. McClanahan says there isn’t so very much difference between pigs and babies in some ways. Both do well on soy beans.

Dr. Jones advises each member of the class to spend ten cents for a cauliflower and use it in practicing diagnosing of carcinoma of the cervix.

On November 24 Dr. Atten of the Methodist Hospital took over Dr. Bridges’ clinic for a few minutes and gave the boys a very learned dissertation on the myelocytes and Bantis disease.

Ordinarily it isn’t advisable to make a diagnosis or prescribe over the telephone. But when in a hurry one of the instructors says to have the mother hold the baby to the telephone, let it cough a few times and croup can be diagnosed, if present, without doubt.

Dr. McClanahan tells us of a case to which he was called in consultation. The radial artery had been severed and the country doctor who had seen the case first had given a bad prognosis based upon the fact that “they always die if they have no pulse.”

The following is copied from an outcall report handed in at the Dispensary by one of the class who is often seen riding a motorcycle and who wears a mustache: Sanitary condition of the house, colored; age, 64; sex, girl.

Dr. McClanahan took roll last week and for the sake of correctness had each name spelled as it was called, but he skipped one name in the proceedings, i. e., Hoffmeister. Evidently he had found out in some other way how to spell George’s name.

The first block of the Senior course came to a close recently when
the finals in Gynecology, Obstetrics and Fractures were given. With them our last sessions with Drs. Findley and Sommers as class room instructors were held and this fact is regretted by the whole class. We are glad, however, that we still continue clinical instruction under these able men.

The intern question is abroad in the class. According to Dr. Cutter, graduates from our school may seek entrance into most of the big hospitals of the country, from New York to San Francisco. Many of these hospitals require examinations and to prepare for these a quiz course is being conducted by Dr. Pratt, who successfully passed the examination for an internship at Cook County Hospital. The class meets bi-weekly for a two hour period, one hour for oral and one hour for written work. The competitive questions from the various schools will be obtained and the examinations will be conducted by the faculty. Judging from the general talk of the men, most of the class will seek their internships in larger institutions that offer more individual work than do the Omaha hospitals.

JUNIOR NOTES.

The class is one that will be remembered in history, on account of the original ideas and theories advanced by some of its intelligent members, or as Richards says, "any individual or a whole class of animals are eligible." He probably referred to the time when we were tree-climbers.

Here is one from the trenches:

Dr. Pilcher—"Talcott, what is a good household remedy?"

"Doc."—"Blue ointment." (Safety first).

Bullet Wounds—Montgomery should be advised that Ingersoll never associated mastitis and mastoiditis.

Sherwood and Maneer have passed the requirements to enter the ambulance squad in that they "clinker," the former before and the latter after class is dismissed, and by so doing try to pick up dead points and keep the battle (class) from clearing.

According to a certain professor, Lake is not much of a squeezer, but we know him to be a teaser.

When Wildhaber comes to class all perfumed up, the odor wakes Gifford from his slumber.

Recently influenza attacked Martin. The battle resulted in "Red's" defeat, and by court martial he was compelled to pass several days of solitary confinement in bed.

A new method of keeping patients in bed discovered at the Methodist hospital: Art. Ross's pajama pants were stolen by a nurse for fear he might get up.

Losey and "Red" Martin are both in the Emergency hospital in the scarlet fever wards. Losey is said to be very sick, while Martin is doing very well.
FRESHMEN NOTES.

Christmas will be more than appreciated by the Freshmen. We can dream of something besides embryo pigs and muscles of the back.

Dr. Poynter compares anatomy to descending a mountain and in the valley below finding a systematically arranged house. The Freshmen figure that it is the ascension of a mountain to find a disagreeable flunk at the summit.

The following diseases, prevalent among the Freshmen, can be cured by sodium salicylate, according to Drs. Sherwood and Talcott: Tonsilitis, pneumonia, diphtheria, Bright's disease, big head and unmanliness. If the Freshmen adopt the motto, "Stick to your salicylate," the amount of sickness will decrease three fold, so say these worthy authorities.

**Anatomy Axioms.**

1. They do not throw liver in the best families.
2. Once a month is not too often to change your lab. suit and socks.
3. A medical pocket dictionary is as useful as was the .44 to the plainsman of old.
4. Do not make nerves with white thread.
5. Do not scratch your head or pick your teeth with the dissecting knife.
6. Four pounds of Java and a cold towel will not pass one in anatomy.
7. Beauty is only skin deep.
8. The intestine is a poor snubbing rope.
9. Learn the meaning of anlage.

Weidman tried to buy a cadaver at the ten cent store.

We suggest that when with your lady friend you do not speak of the subject of anatomy or you may find yourself in the predicament similar to that into which Tony Larsen precipitated himself, when he said:
“I am dissecting a lady stiff in anatomy.”
She—“Oh, how is she dressed?”
Tony—“She is wrapped in her own thoughts.”

Do your Christmas knocking early.

**SOPHOMORE NOTES.**

With the course in Neurology finished a change in the schedule was found necessary. Practically all of Monday, Wednesday and Fridays are to be given over to laboratory in physiology and the Tuesday and Thursday afternoons that were left open are to be used for special readings in that subject.

Nearly all of the men went home to spend the recent vacation under the parental roof and all of them were able to return and resume work the following Monday except Walker. Diagnosis in his case, “too much turkey.”

Did you notice the awful jam in the library the week after vacation? Sophomores, one and all. “There’s a reason.”

“Texas” Brewer was the guest of friends in Nebraska City during vacation. The hospital internship is his, so he says.

Mauer in Quiz—Vitamines are obtained from the head of spermatozoa of deep sea fishes. (Grade—0).

Dr. Guenther—“Mr. Miller, what makes you perspire?” Miller—“Muscular exercise and hard study.”

**New Flagella Stain.**

Delzell, Steenbarg and Beede have developed a new stain to be used after shaving.

Dr. Schultz—“A good many cases of dysentery were contracted during the civil war by men who were in the armies. Some of the civil war veterans had the dysentery until they died; some of them still have it.”

Dr. Schultz—“Mr. Newbecker, if a patient came to you and wanted to be vaccinated, what would you do?”
Newbecker—“I would vaccinate him.”

Dr. Schultz—“Does any one know what animal is used for making a serum that will produce immunity against dysentery?”
Tuck Westover (deep voice)—“The goat, doctor.”
Dr. Schultz—“They might—but they don’t.”
Class—Ha! ha!

Dr. Schultz in Lab.—“In shipping the organisms from New York an interchange was made in labels on Bacterium pneumoniae and Bacterium aerogenes. Rather than write your long detailed outlines over again you can simply change the headings and your notes will then be correct.”

Steve—“Well, my goodness! Now I will have to unlearn all of these outlines and learn them all over again.”
BROKE! BROKE! BROKE!
(After recovering from a doctor’s bill, and with apologies
to Tennyson.)

Broke! Broke! Broke!
And I would that my keys could type-write
In this cold gray town, O gee!
The thoughts that arise in me:
O well for the doctor’s boy,
That he shouts with his sister at play;
O well for the hospital chief,
As he swings in his chair all the day.

And the precious plunks roll on,
To settle the surgeon’s bill,
But O for the touch of a vanished wad,
And the sound of the chink that is still!

Broke! Broke! Broke!
At the end of my rope, O me!
But the pleasant weight of a wallet that’s full
Will never come back to me!

—Des Moines Register.
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