Dorseys, and hosts of others now dead but great in the annals of medical discovery and service, like the laborious Dunglison and others, like Paul Beck Goddard, who should be honored. Why is there not a memorial medical university, not an annex to a literary institution, but an independent exclusively medical university to Ephraim McDowell, to Nicholas Senn, to Valentine Mott and others like them, now gone to the glory of the skies, but not yet properly glorified by us here below in suitable structures of stone?

If we look for the living to memorialize there are the Mayo Brothers of Minnesota. There are Sajous, Shoemaker, and La Place of Philadelphia, to say nothing of Murphy, Finlay, Gorgus, Flexner, Ochsner, Billings, and many others among us yet in other cities and men abroad who have carved deathless names on Fame's memory tablets, and Osler, now not with us, but who worked like a trojan for Johns Hopkins.

At one time St. Louis, through its independent medical schools named after dead medical worthies, did more than any other city to keep the fame of its medical worthies alive by naming its medical colleges after them.

Why not have a renaissance of great men of medicine in memorial educational monuments to the work they did for the world's welfare, not in St. Louis and Chicago alone but in other cities and sections of the country?

Two St. Louis public schools bear the honored names of Pope and Hodgen. Why not name medical schools after them, also; and Watters, Linton, and others of that good old school? I saw John T. Hodgen in the amphitheater of the St. Louis Medical College more than thirty years ago, when he was teaching physiology there, repeat the demonstrations of Flourens on the cerebelli of pigeons and the school was then independent of Washington University, a two-year school with one previous year of home study with a preceptor its minimum requirement.

I saw practical toxicology demonstrated in such a way at the same school that I could never testify that hydrocyanic acid could take all day to kill a man as was testified to as a fact in the recent Hyde trial at Kansas City. This school had no university laboratory connection at that time either.

C. H. HUGHES, M.D., St. Louis.

Registration of Foreign Physicians

To the Editor:—I wish to express my approval of the letter on this subject in THE JOURNAL, August 6. I am a graduate of a medical school in Boston, but a South African by birth and held citizenship rights there before the war with England. Since my graduation here I endeavored to obtain the right of practicing in my own home, which has been denied me because of the laws existing in all British colonies. I have been given the privilege of taking an English degree, should I choose any of the colleges quoted by the council in London. As a means of obtaining this right, it was suggested that I go to Halifax (Nova Scotia) Medical College, where it would be easier to obtain a degree. This particular college has not received the approval of the Council on Medical Education of the American Medical Association or of the Carnegie Foundation. Nevertheless I was advised to go there by the registrar of the Medical Council of London, and to obtain a degree which would enable me to practice in South Africa. Last year, in the Transvaal, after some agitation, through influential friends, a provision was made, which gave the right to the Transvaal Medical Council to grant certain privileges to South-African born students, desiring to attend and graduate from other than English medical schools.

It seems passing strange and unfair that the choice of the place of one's education should be denied to an inhabitant of a supposedly free and liberally governed country. It restricts the practice of medicine largely to the English, a great many of whom are graduates of colleges of not so good a standing as some American ones. If this information and protest will do any good to change the present state of affairs here and demand reciprocal rights, I shall be quite satisfied to remain here in my adopted country.

JAMES A. HONEIJ, M.D., Cambridge, Mass.

The Whistle in the Stomach, Who Blew It First? A Question of Priority

To the Editor:—The story is different from that told by Benjamin Franklin, but the moral is strikingly similar.

Eleven or twelve years ago I was possessed by the ambition to devise a method by means of which the exact length of the esophagus might be clinically determined. While waiting for inspiration I did the customary thing—I whistled. Like Newton's discovery of the law of gravitation at seeing the apple fall, to me, likewise, came the idea while "wetting my whistle." Since my whistling at the esophagus and my whistling for the esophagus were like "whistling jigs to a milestone," why, thought I, whistling, not try to whistle into the esophagus? The result was that I did some more whistling and succeeded in hearing the sound of a whistle issuing from the innermost recesses of the abdominal viscera. To my ear it sounded like the first cry of my first-born.

I gave shape to my thoughts in a paper entitled "The Esophagometer or the Intra-gastric Whistle; A new Device for Measuring the Esophagus in the Living," which was read at the meeting of the Colorado State Medical Society, June 18-20, 1901, and which was subsequently published in the *New York Medical Journal*, Aug. 31, 1901.

I quote here a few lines referring to the principle on which the device is based and the description of the instrument.

My method is based on the principle of acoustics, that sound is produced by the vibrations of air, and on the facts that the stomach is a hollow organ containing air, and that the esophagus when not in the act of swallowing is an air-tight organ. Hence, a musical instrument, when introduced into the esophagus, will produce no sound whatsoever throughout the whole of its length, but so soon as it reaches the threshold of the stomach, the cardia, it will emit a sound.

My device consists of a stomach tube provided at its proximal end with a whistle. . . . The whistle is secured in the tube by tying it externally with a piece of catgut or silk. The tube is introduced into the esophagus, and air blown in by means of a pump, Davidson syringe, Politzer bag, the mouth, or what not. So long as the whistle traverses the esophagus the instrument is smothered and no sound is heard; but, so soon as the cardia is reached a distinct whistle is heard. The tube can be pushed forward and backward several times so as to ascertain the exact point at which the whistle becomes audible. The distance between the distal border of the side opening of the tube and the point at the incisor teeth where the whistling sound is first heard represents with precision the distance between the incisor teeth and the cardia.

An illustration of the instrument accompanied the article.

All these years I have been nursing the belief that I am the only and original whistler who first blew a note into the expanse of the stomach, and that to the end of time wherever the muffled sound of the intra-gastric whistle would be heard, there also the sound of my name would be echoed. But alas, my dream of fame and immortality is now hanging in the balance. There is another man who clamors for the honor and claims the first gastric blast.

Dr. Robert Coleman Kemp, in his treatise on "Diseases of the Stomach and Intestines" (Saunders, Philadelphia, 1910) gives a description and illustration of a stomach whistle which is identical with mine of 1901 vintage. Under the illustration is to be found the modest legend: "Kemp's Stomach Whistle."

The question at issue is: Who of us two whistled first into the stomach, and whether in the subsequent editions of Kemp's excellent treatise the legend under the illustration should be retained or changed.

I paid in full for Dr. Kemp's book and thought it was fully worth the price until I found there the story of the whistle, the moral of which, until proof to the contrary be forthcoming, is that I paid too much for my whistle.

C. D. SPIVAK, M.D. Denver.

[A proof of the above letter was submitted to Dr. Kemp, who replies:]

To the Editor:—Though I exercised considerable care during the preparation of my recent work on "Diseases of the Stomach and Intestines," especially in properly crediting other authors and their investigations, I must frankly confess that I had not seen Dr. Spivak's article or known of its

existence, and therefore did not credit him as the "original whistler." The instrument depicted in my book has a specially made thick-walled bulb attachment and the air is forced into the esophagus and immediately aspirated out, passing through the whistle extremity on both occasions. It will whistle in the esophagus, though to a much less marked degree than in the stomach. Dr. Spivak's references to the principles of acoustics are perfectly correct, but esophageal whistling can be readily produced by forced inspiration and aspiration by my unfortunate instrument.

As to changing the legend under the illustration, every aeroplane is not labeled "Wright," or every esophagoscope with the name of the discoverer of the instrument. There are "others." Dr. Spivak, however, should be duly credited.

Unfortunately, as I am on a summer tour and have no access to my own literature, I can only give approximate dates. My whistle was reported in the *Medical Brief*, I believe, early in 1904 in connection with gastroduaphany and other methods of determining the position of the stomach as a means of comparison; also at an earlier period in the *Medical News*, and was demonstrated previous to this at my clinics at the Manhattan State Hospital. I believe, however, that Dr. Spivak must be the "original whistler" and in the next edition of my book, I shall be pleased to credit him as such. I note with pleasure that he thought my book worth the price until he "ran against" my whistle. I trust that my "amende honorable" will make him hereafter feel that he has not paid too much for his whistle.

ROBERT COLEMAN KEMP, M.D., New York.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

SIGNIFICANCE OF CYLINDROIDS

To the Editor:—Please give answers to the following: 1. What is the origin of cylindroids in the urine? 2. Have cylindroids any pathologic significance? 3. Have cylindroids coated with granules (urates) any significance? 4. Is there any definite means of distinguishing tailless cylindroids from hyaline casts? A. M.

ANSWER: 1. Cylindroids proper are believed to be of renal origin and closely related to true casts; formations are sometimes observed in which there is a tube cast at one or each end of a cylindroid, and continuous with it.

2. Cylindroids are present wherever hyaline casts are seen and have essentially the same significance.

3. The coating of the exterior of the cylindroid with urates would probably be due to the deposition of urates after the cylindroid had left the urinary tubules and would indicate merely a tendency to deposit of urates. Cylindroids with granules in the interior are of somewhat graver import than merely hyaline cylindroids.

4. We know of no means of distinguishing them.

COOPERATION OF THE LARYNGOLOGIST AND THE DENTIST

To the Editor:—In the study of the etiology of the morbid conditions within the nose and accessory sinuses one is struck with the part played by malformations of the septum. Ventilation, functional activity and drainage are not always involved, yet the last ten years of study has told us that this is to the rhinologist what the appendix is to the abdominal surgeon. With any degree of deflection an acute rhinitis or influenza infection is much more likely to produce a sequence of chronic troubles.

According to Freeman and Trendelenburg, the common cause of deflection is the high or gothic arch of the hard palate. According to Schlaus, this may be a form of faulty development with facial bone involvement. With due credit to Talbot this may be a stigma of degeneracy. It is difficult to arrive at any definite conclusion but a high arch is nevertheless common to these cases (as well as in degeneracy as shown by Powell of Chicago). Therefore, why should we not subject growing children with the gothic arch and beginning deflection to the dentist for correction of the deformity before development and ossification are firmly established? Is this not a fertile field for cooperation between the rhinologist and the dentist?

P. J. WALTER, Waterloo, Ia.

ANSWER.—Cooperation of the laryngologist and dentist is frequently important, for the early correction of the gothic arch of the hard palate will undoubtedly help deflection of the septum just

as removal of the adenoids and tonsils will in many cases correct deformities of the teeth. Nevertheless, there is a danger of over-estimating the importance of deflection of the septum. We cannot agree with the statement that "With any degree of deflection an acute rhinitis or influenza infection is much more likely to produce a sequence of chronic troubles."

Fifty per cent. of the Caucasian race have deflection or exostosis of the septum, yet it is only in a very limited number of these that the condition gives rise to any trouble. There is no unanimity of opinion among laryngologists as to the cause of deflection of the septum. Many laryngologists believe that it is due to injury of the nose, yet no proof can be advanced for this theory, because there are very few individuals who do not receive more or less severe bumps on the nose at some time during their lives. The theory that deflection is commonly due to overgrowth of the septum in consequence of a catarrhal condition that brings an excessive supply of blood to the part has many arguments in its favor. As a rule, it is not worth while to operate on young children for deflection of the septum because the condition is very apt to return within a year or two, therefore, if in these children a high arch could be corrected by the dentist it might prove beneficial.

The Public Service

U. S. Public Health and Marine-Hospital Service

Changes for the fourteen days ended Aug. 24, 1910.

Pettus, W. J., asst.-surgeon general, granted 1 month and 15 days' leave of absence from Aug. 29, 1910.

Cofer, L. E., asst.-surgeon general, granted 6 days' leave of absence from Aug. 22, 1910.

Mead, F. W., surgeon, granted 30 days' leave of absence from Aug. 23, 1910.

White, J. H., surgeon, granted 1 month's leave of absence from Aug. 17, 1910.

Williams, L. L., surgeon, granted 7 days' leave of absence from Aug. 11, 1910, under paragraph 189, Service Regulations.

Simpson, W. G., surgeon, leave of absence for 20 days from Aug. 11, 1910, amended to read 6 days from Aug. 11, 1910.

Sprague, E. K., surgeon, granted 1 month's leave of absence from Aug. 28, 1910.

Fox, Carroll, P. A. surgeon, granted 10 days' leave of absence en route to station.

McClintic, Thomas B., P. A. surgeon, granted 7 days' leave of absence from Aug. 15, 1910, under paragraph 191, Service Regulations.

Gwyn, M. K., P. A. surgeon, granted 10 days' leave of absence from Aug. 28, 1910.

Foster, A. D., P. A. surgeon, directed to proceed to New Orleans and report to the medical officer in command for duty and assignment to quarters.

Lanza, A. J., asst.-surgeon, granted 7 days' leave of absence from Aug. 14, 1910.

Marshall, E. R., asst.-surgeon, granted 21 days' leave of absence from Sept. 14, 1910.

Krullish, Emil, asst.-surgeon, granted 1 month's leave of absence from Aug. 16, 1910.

Duffy, Benedict J., asst.-surgeon, directed to report to the medical officer in command at Buffalo, N. Y., for duty Aug. 12, 1910.

Cleaves, F. H., acting asst.-surgeon, granted 14 days' leave of absence from Aug. 7, 1910.

Gleason, C. M., acting asst.-surgeon, granted 14 days' leave of absence from Aug. 15, 1910.

MacCallum, Charles, acting asst.-surgeon, granted 30 days' leave of absence from Aug. 12, 1910.

Schuster, B. L., acting asst.-surgeon, granted 4 days' leave of absence from Sept. 1, 1910.

Wright, F. W., acting asst.-surgeon, granted 12 days' leave of absence from Sept. 1, 1910.

Duffy, Dr. Benedict J., commissioned (recess) an asst.-surgeon in the Public Health and Marine-Hospital Service, Aug. 5, 1910.

Wickes, Henry W., P. A. surgeon, commissioned a surgeon (recess) to rank as such from Aug. 3, 1910.

Book Notices

AGE INCIDENCE, SEX, AND COMPARATIVE FREQUENCY IN DISEASE. By James Grant Andrew, Bachelor of Medicine and Master of Surgery. Cloth. Price, \$4.20 net. Pp. 439, New York: Paul B. Hoeber, 69 E. 50th St., 1909.

This book represents a comparative study and tabulation of over 42,000 cases from a single institution, covering diseases of all the different systems, classifying them by sex and the decennial age periods, and giving the results in number of cases and percentages. It represents an enormous amount of work, but its value in many instances may be open to question, on account of the small number of cases available. For instance, in a total of less than 400 bladder affections, only two cases of enuresis are recorded, and deduc-