excellent physical condition at the time this membrane was given, but thirty-seven days later he showed the first symptoms of the disease. There was anorexia progressive emaciation, prostration and intractable diarrhoea. The characteristic skin lesions, involving the fingers, lower portions of the forearms and elbows, followed the digestive symptoms. Nineteen days after the first symptoms appeared the animal died.

Autopsy showed congestion and superficial necrosis of the intestinal tract with engorgement of the mesenteric vessels. There was a thick mucopurulent exudate in the colon, sigmoid and rectum.

Cultures were made from feces and Dr. Dearmon isolated a bacterium which closely resembles the colon group. Blood serums from the monkey agglutinated in dilutions of 1-100, while blood serum from healthy monkeys and individuals showed no agglutinating properties with the bacilli.

Dr. Dearmon thinks that pellagra is an infectious disease, primarily a gastro-intestinal disorder, caused by a specific bacterium which he believes he has isolated.

Dr. Dearmon's technique is apparently good and, while positive deductions cannot be drawn from one case, his results are certainly suggestive, and we hope that he and others will continue this line of investigation. We will admit, however, that it will take very strong proof to convince us that the origin of pellagra does not exist in spoiled corn. We hope also that Southern men will continue investigations with maize products in the endeavor to find the etiological factor in pellagra.

We should like for the Southern Medical Association to have the privilege of awarding its research medal to one of our members for discovering the specific origin of pellagra.

THE STATE MEDICAL SERVICE ASSOCIATION.

Over in England a number of physicians have formed an association for the purpose

of bringing about a sort of union between medicine and state, whereby every competent practitioner shall be assured of a livelihood and a pension, and every citizen shall receive all necessary medical and surgical attention, and all the hospitals are to be nationalized for the benefit of doctors and patients, or used for purposes of research.

If the object were to stifle ambition by removing its necessity and rewards, to drill medical men to one dead level under military discipline until its members would become cold, unsympathetic cogs in a machine, and the whole body a distinct and separate class supported by taxation, no more insidiously effective plan could be devised.

Far better is our American freedom to work or starve, our American way of seizing opportunity and making it pay tribute to American energy and ability and our American love of the admiration and honor to be won by distinguished service.

The dead level of Socialism has no equivalent to offer for the noble duties and splendid opportunities that today confront the American physician.

THE NATIONAL DRAINAGE CONGRESS.

The immense importance of the gigantic task the above-named organization has undertaken to study and facilitate is well expressed in a communication sent by Woodrow Wilson, President of the United States, to the Chairman of its Executive Committee on the 27th of last March, as follows:

"I regret that it is impossible for me to attend the sessions of the National Drainage Congress. The calamity in Indiana and Ohio makes clearer than ever before the imperative and immediate necessity for a comprehensive and systematic plan for drainage and flood control. I very earnestly hope that your deliberations may mark a long step forward in this direction. Accept my best wishes for a successful meet. WOODROW WILSON."

One of the most important actions of the Congress was the permanent organization of "The Malarial Section of the National Drainage Congress." Dr. Oscar Dowling, of Louisiana, was chosen President, and he has since appointed Dr. W. H. Deaderick, of Arkansas, Secretary. An Executive Committee, with one member from the United States Public Health Service and one from each of fourteen of the Southern States was elected. The list reads like a roll call of the Southern Medical Association, and is as follows:

Dr. R. H. Von Ezdorf, United States Public Health Service, Mobile.

Alabama—Dr. Seale Harris, Mobile.

Arkansas—Dr. Morgan Smith, Little Rock.

Florida—Dr. A. N. Fernandez, Jacksonville.

Georgia—Health Officer of Savannah.

Kentucky—Dr. A. T. McCormack, Bowling Green.

Louisiana—Dr. C. C. Bass, New Orleans.

Maryland—W. H. Manss, Baltimore.

Missouri—Dr. F. B. Hiller, Jefferson City.

Mississippi—Dr. W. H. Rowan, State Board of Health, Jackson.

North Carolina—Dr. W. S. Rankin, Raleigh.
South Carolina—Secretary of State Board of Health.

Tennessee—Secretary of State Board of Health.

Texas—Ralph Steiner, Austin, Commissioner of Health.

Virginia—Dr. A. W. Freeman, Richmond.

With such a battery of physical energy and practical knowledge as the motive power of the committee the safeguarding of the country against malarial infection will surely be energetically presented to public and official attention. Drainage and irrigation can make a swamp into a garden, but only by suppressing the anopheles can its continued prosperity be assured.

CORRESPONDENCE

Isthmian Canal Commission, Canal Zone.

Ancon Hospital, Ancon, C. Z., April 3, 1913.
Editor Southern Medical Journal:

With regard of the treatment of malaria. I do not claim that the method represented in the paper I sent is infallible. But since you say that you wish to bring the matter up in The Southern Medical Journal, permit me to call your attention to the principles of the treatment.

We sent out a year or so ago circular letters to leading authorities throughout the world with regard to the problem of relapse. Practically all agreed that from 50 to 80 per cent of total attacks of malaria were due to relapse. This was the opinion of very high authorities who have studied the question in countries where relapse can be determined, people such as Marchiafava, Celli, Ross, Patton, and in the States, Craig, Deaderick and Henson.

Now, if these people find this per cent of relapse after the best authorized treatments, evidently the treatments did not eliminate the parasites. As I said in my last letter, it makes but little difference which hypothesis one holds as to the etiology of relapse, all agree that there is a

resistant form that quinine does not touch, and that once this form has been generated in the human host, quinine will not dislodge it. This is certainly so, since after any system relapses follow. The point is, not how to get rid of the resistant forms, for there is no evidence to show that they can be dislodged, but how to prevent their generation. I have seen a relapse after two intravenous injections (22 1-2 gr.) and 45 grains per day for a week, followed by 30 for another week. In this case there was a history of taking small doses for a considerable period, just enough to abort the attacks, with the result that the resistant forms had been generated, so that I did not kill them. Similar cases are cited by Bignami in his article that you printed in February, and are doubtless known to you.

Now, it is a well-known fact that the sooner and the more thoroughly the primary attack, or one of the relapses is treated, the better chance there is of preventing subsequent attacks. This, I believe, is because, as Bignami says, during the febrile stages the parasites are more amenable to the action of quinine. There is no direct proof of this; but one can imagine that the resistance is confined to the smaller number of whatever forms