that the suppression of public prostitution would, on the whole, be a benefit to public health.

If we wish to contend with this terrible class of diseases, it is above all necessary that venereal patients should have medical attendance at their disposal. The system in action up to the present time alienates these patients through fear of reprobation or of punishment, while it should, on the contrary, take into consideration only their sufferings and hold itself aloof from the misconduct which has occasioned them. The patient should no longer be withheld from seeking the necessary assistance by unwarrantable restrictions. Measures of relief should be distributed with a liberal hand. By these means positive results will be obtained of infinitely more service than the total uncertainty attending the system now in action, which I do not hesitate to oppose.

AMPUTATIONS BELOW THE KNEE.

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There is little in this subject of technical interest to the surgeon of to-day; it is such an old subject, its technic is so familiar and its performance so simple. Surgeons are looking for greater things, therefore the immediate result is about all they observe and but seldom stop to consider carefully the most important question relative to these amputations, the ultimate usefulness of the stump.

Having been called on three times during the past year to make leg amputations where the Chopart stump was so painful that use was impossible, having also noted the wide differences of opinion among surgeons and also among artificial limb makers, as to the value of these various amputations, I resolved to secure the opinion of the most practical and to compare notes.

I addressed circular letters to 100 surgeons and 35 limb makers, receiving reply from 96 surgeons and all of the latter. The following is a brief summary of these replies:

QUESTIONS ADDRESSED TO ONE HUNDRED SURGEONS.

1. "Where it is possible, would you advise the Lisfranc amputation or any of its modifications?"

Twenty-four answered "No," 4 answered "Yes" conditionally, and 63 "Yes," many of the latter indicating a preference for the Hey modification.

Of these amputations 364 were reported to me with slightly over 20 per cent. reported as "unsatisfactory" and 7 had sought amputation of the leg.

2. "Where it is possible, would you advise the Chopart, Pirogoff, Symes or any other amputation through the foot?"

(A) CHOPART: Fifty-seven answered "No," and 34 answered "Providing there is plenty of plantar tissue accessible, Yes."

Of 241 cases reported, over 73 per cent. were reported as "unsatisfactory," and 47 had sought amputations higher up.

(B) PIROGOFF: Sixty-six answered "No," and 22 answered "Yes."

Of 152 cases reported, nearly 61 per cent. were reported "unsatisfactory," and 18 had sought amputation of the leg.

(C) SYMES: Seventy-six answered "No," and only 9 answered "Yes."

Forty-three cases were reported with 9 "unsatisfactory," and 2 of these had sought amputation of the leg.

3. "Where the foot must come off, where would you elect to amputate?"

Seven answered "at ankle joint"; 14 "as low as possible"; 9 "three inches above ankle joint"; 16 "just above middle lower third"; 12 "junction of upper with middle third"; and 46 "junction of lower with middle third."

Fifty-eight of these surgeons reported having made over 1,200 amputations, the remainder had no available records.

QUESTIONS ADDRESSED TO THIRTY-FIVE LIMB MAKERS.

1. "Can artificial appliances be made useful in the Lisfranc amputation of the foot or its modifications?"

Twenty-six answered "Yes"; 4 answered "They can, but they are not always satisfactory, as patients frequently return complaining of pain and are unable to walk"; while 5 answered positively "No."

2. "Can artificial appliances be made useful, as to restoration of gait and usefulness of foot in amputations through the foot as in Chopart, Pirogoff, Symes and other methods?"

(A) CHOPART: Twenty-four answered "No," and 9 answered "Yes."

Many of those answering in the negative gave as their reasons that "Surgeons are not careful enough in making such amputations," and that "the scar is often adherent, not far enough back, and the stump is extended."

(B) PIROGOFF: Five answered "Yes, in selected cases," while 26 answered "No."

(C) SYMES: Twenty-two answered "Yes," and 9 answered "No, except in selected cases."

3. "If the foot must come off, where should the amputation be made?"

The universal answer was "from six to nine inches below knee, measuring from lower border of patella."

4. "What kind of flap makes the best stump for fitting an artificial limb?"

Nearly all of them answered "Long anterior with short posterior, bringing the scar well back with loose normal skin covering end of bone."

Sad differences of opinion are at once seen. Surgeons differing with each other and limb makers with each other, and the one class differing with the other on many vital points. This is especially noticeable concerning the Symes amputation, where 76 surgeons advise against the operation, with 9 in favor of it, while 21 limb makers favor the resulting stump, to 9 who do not, except in selected cases.

As surgeons, we must recognize the wide experience and ability of our best artificial limb manufacturers. They see the patient many times after we have lost sight of him; in fact, he is forever haunting them with all his misfortune. The question that should engage our serious consideration is: Where and how shall we amputate? considering carefully the future comfort, physical requirements and the possibilities of our patient.

Dr. Fred Murphy of Boston, after making his "Study of Amputations of the Lower Extremity," says: "In going over this subject exhaustively, I found that surgeons themselves had very little idea of the after results in these cases." He also says: "Before my investigation I was enthusiastic as to the value of partial amputations of the foot, but after seeing and talking with the patients I was forced to believe, that as a routine, there is nothing so satisfactory as a good tibial stump of medium length." Again he says: "The makers of artificial limbs tell fine stories about the apparatus that they can fit to these partial amputations, but with very few exceptions they have, in my experience, proved to be most unsatisfactory."

The prevailing complaints among the limb makers against the partial amputations of the foot are "weak supporting arch," "extension of stump," and "insufficient flap and faulty position of scar, which is often adherent and tender."

The old theory of saving all that you can, applied to amputations below the knee, is certainly very absurd, and no intelligent surgeon of to-day would give it even a passing thought.

I believe that no partial amputation of the foot should be made which does not afford sufficient plantar bearing surface to carry the entire weight of the body, with

ample flap to form loose covering over end stump and to bring scar well back out of line of pressure. I believe that an ideal leg amputation is superior to many Chopart or Symes and most Pirogoff amputations. The Lisfranc, especially the Hey modification, gives a very satisfactory stump. I wish to suggest, however, that in making this amputation, it is wise to preserve the attachment of the tibialis anticus, when possible, and if not, to attach its tendons to the plantar flap. This same rule applies also to the peroneus tertius.

In making amputations of the leg, there are a few important details which we should not lose sight of:

1. Be certain of sufficient flap to properly cover end of bone, regardless of how close this may come to the knee joint. Flap must be considered first, length of stump second.

2. The most uniform good results are obtained by making the long anterior with short posterior flap, bringing the scar well away from end of stump.

3. Redundancy is always undesirable.

4. When the length of stump is at the discretion of the operator, it should be from six to nine inches below lower border of patella.

5. Periosteal flap with coaptation of muscles over end of bone is always desirable.

6. Always cut the fibula one inch shorter than the tibia and when the amputation is near the knee joint, disarticulate and remove the fibula.

7. In all these amputations, nerves should be drawn out and cut as short as possible.

THE EVILS OF PROPRIETARY MEDICINES.*

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Many preparations are passed off on our profession by apparently reliable manufacturing houses as ethical proprietary preparations or as definite, synthetical compounds that are not only simple nostrums, but some may be classed as base deceptions. The unsuspecting physician is victimized by these deceptions, is misled by their advertising literature termed "modern therapeutics," and prescribes for his trusting patients these advertised remedies, which are high in price and of whose composition he is either partly or wholly ignorant.

The nostrum evil flourishes more in this country than in any other. To classify the many proprietary preparations, to sift the true from the false, the really ethical from the nostrum, is a difficult matter.

Some medicines are patented, which protects the patentee for seventeen years, but these are not secret, because from the patent office anyone can obtain the description, composition and the method of manufacture. The patent serves simply to increase the cost to the consumer by giving one manufacturer the exclusive right to manufacture the article.

According to the dictionary, a nostrum is "a medicine, the ingredients of which are kept secret for the purpose of restricting profits of sale to the inventor or proprietor; a quack medicine." In this pernicious class are those preparations that are protected by trademark or copyrighted name, and the composition of which is either kept absolutely secret, or there is a pretense of a formula. This secrecy or semi-secrecy is really considered of little moment by the manufacturer, who lays his main stress on expounding the indications

for the use of the remedy in a long list of symptoms and ailments which are equally legible to the uneducated and educated in medical matters.

There are two kinds of nostrums and there is no difference between them technically—the secret proprietary preparations manufactured for physicians and advertised lavishly in the medical press, and the common "patent medicines" advertised in the public press. On the one hand the indications for use are couched in medical language, as "Dioivurnia," or "Hayden's Viburnum Compound is the most beneficial remedy known to medical science for dysmenorrhea," etc.; and on the other hand, the wonderful usefulness of the recent marvelous discovery is explained in the language of the public as "Lydia E. Pinkham's Vegetable Compound absolutely cures painful monthly periods and elevates a fallen womb."

The physician abhors the patent medicine evil; yet he reads the literature of the proprietary manufacturers, exploiting their wares, and follows their directions in prescribing to his trusting patients. He is simply being used as a middle-man to distribute these "cure-alls" to the public in general. He is paving the way for ultimate counter-prescribing and ultimate self-medication.

It is difficult to understand why we call medicines and preparations that are advertised in newspapers "patent medicines," and those that are advertised in medical journals "proprietary" or "ethical," when the claims of the two are so much alike and the degree of secrecy equal. The layman can naturally accuse the physician of making a distinction without a difference. Some are so bold and brazen as to make no attempt to tell what the nostrum is, whether it is some real drug or nothing but dirt and syrup. Others make a pretense of giving a formula, with or without amounts. They may give the true formula or simply "a formula" or no formula whatever—not for the benefit of the prescribing physician, but to make the article more easily salable through the medical profession and more profitable to themselves. A favorite and successful method is to give a list of ten or twelve drugs, about two of which are common ones of definite known value that we all use, and the others inert, useless ones with high-sounding and unfamiliar names—the latter serving as a cloak for the formula and giving the impression of some great and potent mixture, "the result of years of medical research." The most dangerous of evils lurk in such deceptions.

A manufacturer of drugs in general and nostrums on the side, as so-called specialties, who uses such methods may justly be the subject of suspicion in all his products. Matters of truth, veracity, honesty and efficiency are of little importance. The sole aim of such manufacturers is to make a product salable and as profitable to themselves as possible. An illustration of their veracity and reliability can be gained by a quotation from THE JOURNAL of the American Medical Association of a recent incident:

A firm which had been making a proprietary tablet for years had published a certain formula; recently they changed this by adding eight grains of another drug. The pharmacist in question made inquiries of several chemists about this drug and they all assured him that they had never heard of it. He then wrote to the manufacturers of the tablet, asking them if they had changed the ingredients of their preparation, and they made the following reply: "We have not changed the tablet—we only changed the published formula." We wonder how often the opposite is true, that the published formula remains as it was while the ingredients are changed.

* Read before the Eastern Hospital Graduates Club and the Lane County Medical Society.