Water-Soluble Matter.—All specimens when tested for excess of water-soluble matter came well within the limit (0.50 per cent.) set by the French pharmacopeia, the greatest amount being 0.20 per cent.

Ash.—When heated, all the specimens were found to yield practically no ash, the residues from 1 gm. samples weighing in no case more than 0.0004 gm.

Absence of Paraphenetidin.—When tested by the methods of the United States, British, German and French pharmacopeias, the absence of an impurity of paraphenetidin was shown in all specimens, with the exception of one specimen obtained from Powers-Weightman-Rosengarten Co., which gave a positive, though not strong, reaction and two other specimens of the same firm which reacted still more faintly. While this firm's product alone gave any reaction whatever when the U. S. P. test for paraphenetidin was applied with the test of the Swiss pharmacopeia, all but Acetphenetidin (Mallinckrodt), Acetphenetidin (Merck) and one specimen of Powers-Weightman-Rosengarten Co. gave positive, though very faint reactions, indicating that the majority of specimens, including those of the original manufacturer, contain a minute trace of this impurity.

Our findings regarding the product of Powers-Weightman-Rosengarten Co. having been communicated to this firm, their correctness was acknowledged. At the same time the firm wrote: "All that we have on hand now gives negative tests for paraphenetidin, and we believe our present records are correct when we state that all lots which we are supplying now, and have been supplying for sometime past, answer all U. S. P. requirements."

The above results arranged in tabular form to facilitate comparison of the various specimens are herewith appended:

TABLE SHOWING RESULTS OF ANALYSES OF VARIOUS SPECIMENS OF ACETPHENETIDIN AND PHENACETIN *

Name	Physical Appearance	Melting-Point (Corr.) C.	Water-Soluble Matter in Per Cent.	Ash, Per Cent.	Paraphenetidin, U. S. P. Test †	Paraphenetidin, Swiss Test †
Acetphenetidin (Farbenfabriken)	Very fine homogeneous crystalline powder.	134.2	0.17	0.02	—	+
Phenacetin (Farbenfabriken) (1)	Very fine homogeneous crystalline powder.	134.5	0.10	0.01	+	+
Phenacetin (Farbenfabriken) (2)	Very fine homogeneous crystalline powder.	133.7	0.06	0.00	—	+
Phenacetin (Lehn & Fink).	Fine crystalline powder, not uniform.	134.7	0.11	0.02	—	+
Acetphenetidin (Lehn & Fink).	Fine crystalline powder, not uniform.	134.8	0.13	0.00	—	+
Acetphenetidin (P. W. R.) (1)	Homogeneous crystalline powder.	134.3	0.19	0.03	+	+
Acetphenetidin (P. W. R.) (2)	Homogeneous crystalline powder.	134.7	0.16	0.02	+	+
Acetphenetidin (P. W. R.) (3)	Homogeneous crystalline powder.	134.7	0.14	0.02	+	+
Acetphenetidin (P. W. R.) (4)	Fine crystalline powder.	133.6	0.20	0.01	—	—
Acetphenetidin (Squibb).	Fine crystalline powder.	134.3	0.19	0.00	—	+
Acetphenetidin (Merck).	Fine crystalline powder.	134.8	0.15	0.03	—	—
Acetphenetidin (Mallinckrodt)	Fine crystalline powder.	134.2	0.11	0.01	—	—

* In all cases identity was confirmed; acetanilid was absent; carbonizable matter was absent.

† In this column plus indicates presence; minus, absence.

This examination would appear to demonstrate that the chemical substance, para-acetphenetidin, whether sold as acetphenetidin, U. S. P., or as phenacetin, is practically identical. The impurity of the product of some of the specimens coming from Powers-Weightman-Rosengarten Co. is too slight to be considered dangerous. Furthermore, a comparison of the "lot numbers" indicates that this firm has been improving its product steadily so that in the future its assurances of an unimpeachable product may be relied on. Inasmuch,

therefore, as acetphenetidin complies with all the pharmacopeial requirements as to identity and purity, in just the same way as phenacetin, which sells for as high as five times the price of acetphenetidin, physicians need not hesitate in using the title of the U. S. P. "acetphenetidin" when prescribing this product.

Association News

THE ATLANTIC CITY SESSION

Announcement of Committees and Hotels for the Next Annual Session of the Association in June

Dr. W. P. Conaway, 1723 Pacific Avenue, Atlantic City, is chairman of the Local Committee on Arrangements for the next annual session of the American Medical Association, at Atlantic City, N. J., June 4 to 7, 1912.

HOTEL HEADQUARTERS

The following hotels have been selected as the various headquarters:

GENERAL HEADQUARTERS: Marlborough-Blenheim.
HOUSE OF DELEGATES: Traymore.
PRACTICE OF MEDICINE: Dennis.
SURGERY: Chalfonte.
OBSTETRICS AND GYNECOLOGY: Haddon Hall.
OPHTHALMOLOGY: Strand.
LARYNGOLOGY, OTOTOLOGY AND RHINOLOGY: Seaside.
DISEASES OF CHILDREN: Traymore.
PHARMACOLOGY AND THERAPEUTICS: Dennis.
PATHOLOGY AND PHYSIOLOGY: St. Charles.
STOMATOLOGY: Young's.
NERVOUS AND MENTAL DISEASES: Brighton.
DERMATOLOGY: St. Charles.
PREVENTIVE MEDICINE AND PUBLIC HEALTH: Shelburne.
GENITO-URINARY DISEASES: Rudolf.
HOSPITALS: Rudolf.

CHAIRMEN OF SUBCOMMITTEES

The following are the names and addresses of the physicians who are chairmen of the various subcommittees of the Committee on Arrangements:

FINANCE: George Scott, 1109 Pacific Ave.
ENTERTAINMENT: J. C. McVay, 707 Pacific Ave.
SECTION ENTERTAINMENT: Bernard R. Lee, 901 Pacific Ave.
HOTELS: W. E. Darnall, 1704 Pacific Ave.
HALLS AND MEETING PLACES: David Berner, 1509 Pacific Ave.
SECTION MEETING: Samuel Barbash, 1902 Pacific Ave.
PROGRAM: Jay I. Durand, 1616 Pacific Ave.
PRINTING: I. E. Leonard, 2842 Atlantic Ave.
BADGES: Thomas G. Dunlap, 921 Pacific Ave.
SCIENTIFIC EXHIBIT: W. J. Carrington, Ryanhurst Apts.
REGISTRATION: H. T. Harvey, Morris and Atlantic Aves.
INFORMATION: M. S. Ireland, 23 S. California Ave.
ALUMNI ENTERTAINMENTS: W. C. Wescott, Delaware and Pacific.
POSTOFFICE AND TELEPHONES: E. C. Chew, 603 Pacific Ave.
COMMERCIAL EXHIBIT: Edward Gulon, 34 S. N. Carolina Ave.
LADIES' ENTERTAINMENT: Mrs. W. Blair Stewart.

Correspondence

An Appeal for a Monument in Honor of John Morgan, Founder of the First Medical School in the United States

To the Editor:—John Morgan was born in Philadelphia, in 1735. He received his A.B. degree from the College at Philadelphia, now the University of Pennsylvania, in 1757. He was graduated doctor of medicine from the University of Edinburgh, and became a licentiate of the Royal College of Physicians of London, and later a fellow of the Royal Society.

During the revolutionary period, Dr. Morgan was director-general of the hospitals and physician-in-chief of the American Army. He was also a member and secretary of the American Philosophical Society of Philadelphia, and in 1787 a fellow and one of the founders of the College of Physicians of Philadelphia, and later one of its censors.

In 1765, he persuaded the trustees of the College of Philadelphia to organize the first medical school in America, and in this institution he became a professor and lectured for three years. He was thus in the fullest sense the father of medical education in the United States of America.

He died Oct. 15, 1789, and lies buried within St. Peter's Church, Philadelphia. No monument marks the place where his remains repose, and it seems desirable to the Philadelphia medical alumni of the University of Pennsylvania that the name of John Morgan should be fittingly honored by some appropriate monument.

It is believed that the medical profession in general in the United States, and all who directly or indirectly have owed anything to medical education, will heartily approve of this movement. Much has been done to commemorate the heroes of war, but to few men indeed does the country owe a heavier debt than to John Morgan, who is certainly the undisputed parent of our first medical school, and therefore of medical education throughout the country. It is hoped, therefore, that all medical institutions here and elsewhere may be in sympathy with this commemorative movement and unite with us in suitably marking the last resting-place of John Morgan, and erecting a monument in memory of his great services to the medical profession.

Subcommittees (a list of which will be published later) have been formed in various parts of the country for the purpose of soliciting financial aid from those interested in the undertaking.

EDGAR FAHS SMITH, M.D., S. WEIR MITCHELL, M.D., WILLIAM OSLER, M.D., WILLIAM PEPPER, JR., M.D., CLARENCE PAYNE FRANKLIN, M.D.

SWITHIN CHANDLER, M.D., Chairman, Philadelphia.

Bronchoscopy

To the Editor:—The interesting report (THE JOURNAL, Feb. 17, 1912, p. 467) of a few cases of "Tacks and Nails in the Air Passages; Bronchoscopy," by Dr. E. Fletcher Ingals, emphasizes and vividly portrays "the heart-breaking delays, the extreme anxiety for the patient and the knowledge that prolonged operations of this kind are dangerous, while failure may spell death for the patient, place the operator under such circumstances under an indescribable stress." The subsequent dangers of edema of the upper air-passages or even of edema of the lung and of a fatal bronchitis or bronchopneumonia are referred to.

I know of one case in a New York hospital in which death resulted in a child of about 1 year, as the bronchoscope was introduced. The difficulties of bronchoscopy, even in such expert hands as Ingals', are well shown in the cases cited, though the site of the foreign body was located by a radiograph.

The time occupied in clearing the field of blood, mucus, pus, etc., is considerable. The danger of the foreign body slipping from the grasp of the forceps is evident, necessitating renewed search and further manipulation. The prolonged anesthesia is not without its incidental disadvantages.

In Case 1, after prolonged effort to control bleeding and to clear the field, occupying one hour, the tack was brought to view and grasped. Too large to be drawn into the bronchoscope, it was withdrawn with the instrument but escaped at the glottis. Further search, continued for a half hour, failed to find the tack. When the instrument was withdrawn, the tack was discovered in the mouth. In another case he had a similar experience. Case 2 necessitated a second operation, fifteen days later, preceded by a tracheotomy, in order to remove the tack which had slipped out of the grasp of the forceps at the first attempt and taken a new position. In the third case, one of eight years' standing, unusual difficulty was experienced from an obstruction 3 cm. below the glottis, necessitating a low bronchoscopy.

It may be presumption on the part of a general practitioner to dare to criticize the work of an expert. Contrast, on the other hand, the picture of the removal of a foreign body by means of the fluoroscopic screen as described by

myself and Dr. R. T. Morris in *Surgery, Gynecology and Obstetrics*, May, 1910, pp. 524-529.

The patient is placed on a wooden table (the x-ray tube beneath) and after a low tracheotomy has been performed, a pair of forceps is passed down to the site of the foreign body. The shadow picture on the fluoroscopic screen placed against the anterior chest enables the operator to direct the forceps to the desired spot with a minimum of trauma to the delicate mucous membrane. The presence of bronchial secretion of mucus, mixed pus, pus or blood in no way interferes with the manipulation. In my own case, the exposure to the x-rays as timed by Dr. Hirsch did not exceed two minutes. The entire operation in Dr. Morris' case occupied thirty minutes.

I adopted this method at the suggestion of Dr. I. S. Hirsch. Subsequently, we found that Dr. Samuel Lile had suggested the method in a short article in the *Virginia Semi-Monthly*, Feb. 8, 1901.

Dr. Maurice D'Halluin, Lille, France, a few years ago, proposed as new the same procedure. Dr. Morris' case and my own, it is true, were recent cases. It may be argued that in cases of long standing, this method may not be as easy; that possibly there may be serious hemorrhage from the granulations, etc.

I notice that in Dr. Ingals' Case 2, he was compelled to push the forceps blindly through the granulations in order to seize the tack. Four times the forceps slipped and the last time, as the tack nearly reached the glottis, it again slipped and a second operation was necessary fifteen days later.

If such an accident occurs when a fluoroscopic screen is used, the body can be easily located by the shadow on the screen and removed promptly. The hemorrhage from granulation tissue, though profuse, is not dangerous as a rule. The fact that a preliminary tracheotomy is required is not a valid objection, for in two of Ingals' cases similar measures were necessary.

FRANCIS HUBER, M.D., New York.

[The above was referred to Dr. Ingals, who says:]

To the Editor:—This method has been employed occasionally since the early days of bronchoscopy, and at times must be a great help. This article, however, would lead the average man to suppose that if he was to use the fluoroscope, there would be very little difficulty. Such an impression would be very unfortunate. Some cases of bronchoscopy are very easy, and others, like the selected ones that I referred to, are difficult. The more one does of this work, the greater is his appreciation of the difficulties.

E. FLETCHER INGALS, Chicago.

Epidemic of Small-Pox in Alaska

To the Editor:—Last summer, at the opening of the Yukon river navigation, an outbreak of small-pox occurred at Dawson, the infection probably brought by some early traveler from the "outside." Much inconvenience to the steamboat companies and the traveling public was caused by the quarantine which it was necessary to set up against Dawson. But prompt measures taken by the Canadian health officer, Dr. Thompson, and the American army surgeon, Dr. Suggs at Fort Egbert (Eagle), just across the boundary line, were effectual in preventing the spread of the disease down the 2,200 miles of open river, and up the many tributaries.

To this statement there is one exception: the joint American and Canadian survey parties engaged in delimiting the boundary between the United States and Canada, along the 141st meridian, got out of Dawson before the disease had declared itself, and proceeded to their point of operations on the Porcupine River some 600 miles from Dawson. Someone in the train of this expedition must have carried the infection, for shortly after its arrival at the Rampart House, small-pox broke out among the natives.

Dr. Gilbert Smith, surgeon of the American survey party, was fortunately on the spot, and at once took action against the spread of the disease. Sending an express to Dawson, the Canadian authorities immediately invested him with full