

cause they were completed by death, whereas the contemporary cases which would nearly all recover, could not be included until completed. Thus the above figure is too high. The total mortality of the vaccinated cases is 14 per cent.; of doubtful cases, 65; and of unvaccinated cases 50.5. Considering the statistics according to age, under 10 there were only 12 vaccinated cases and no death; 6 doubtful cases, all of which were fatal, and 95 unvaccinated cases of which 52 (54.7 per cent.) were fatal. Under 20 there were 161 vaccinated cases, of which 3 (1.87 per cent.) were fatal; 12 doubtful cases, of which 7 (58 per cent.) were fatal; and 161 unvaccinated cases, of which 79 (49 per cent.) were fatal. There appears to be a distinct diminution in the protective power of primary vaccination after the age of 20, the death-rate rising from 9.85 in vaccinated cases between the ages of 20 and 25 to 28.95 in cases between 35 and 40. The neglect of vaccination is strikingly disclosed by one fact: 21 patients who had been employed in disinfecting work by the various local health authorities were admitted. Not one of them had been vaccinated since infancy. There were also admitted 2 sanitary inspectors, 2 dustmen, 1 undertaker, 1 medical officer of an infirmary who had not been revaccinated. Contrast this with the experience of the management of the smallpox hospitals and of the ambulances. All the persons employed are revaccinated on engagement. Of 2198 persons employed between 1884 and 1900, during which period 17,900 cases were received, only 17 contracted smallpox. Of these 13 were not revaccinated until after they had joined and 4 were workmen who had escaped medical observation. Not one of the hospital staff has ever died of smallpox, and not one has ever suffered from the disease for the past eight years.

The Journal of Obstetrics and Gynecology of the British Empire.

This new journal begins with the present year and will be published monthly. It is not published under the auspices of any society, but the members of the Obstetrical Society, which has a chronic feud with the British Gynecological Society, are its principal backers. It may be remembered that two years ago the latter attempted to organize an International Gynecological Congress in London, but was unable to do so in consequence of a boycott by the members of the former society who alleged that the organizers of the Congress were not sufficiently "representative." Thus the promoters of the new journal include a large proportion of the most important names in British gynecology and obstetrics, and the need of a journal devoted to these subjects which is not the mere record of the proceedings of a single society is obvious. The chief editor is Mr. Alban Doran, Surgeon to the Samaritan Free Hospital, who combines distinct literary ability with his special gynecological knowledge. With him are associated a number of distinguished collaborators in all parts of the empire. He is to be congratulated on a very excellent first number. The object is to make the publication a complete and impartial record of British obstetrical and gynecological practice and a summary of contemporary thought and achievement in obstetrics and gynecology throughout the world. The annual subscription is 25 shillings, and the publishers are Balliere Tindall & Co., 8 Henrietta St., Covent Garden, London. The first number shows great promise. The place of honor is occupied by "An Analysis of 100 Cases of Uterine Fibro-Myoma," by Dr. Cullingworth, Obstetric Physician to St. Thomas' Hospital, London.

Gastro-Enterostomy for Severe Hematemesis.

At the Edinburgh Medico-Chirurgical Society Mr. Alexander Miles showed a patient after gastro-enterostomy for severe hematemesis. A woman, aged 42, was suddenly seized with severe hematemesis. Four years previously she had been treated for dyspepsia, and the stomach, which was dilated, had been frequently washed out. She had never vomited blood nor exhibited any of the ordinary signs of gastric ulcer. She regained normal health and remained well until September 8, when the hematemesis occurred. The usual methods of treatment were unsuccessful in arresting the bleeding which continued for three days. As life was endangered, operation was advised. On opening the abdomen by a mesial incision a densely indurated ulcer of about the size of a 5-shilling piece was found close to the pylorus. It extended to the lesser curvature and fully two-thirds of the way to the greater curvature. It was therefore impossible to invaginate it without great risk of occluding the pyloric orifice, and the condition of the patient did not justify an attempt to excise the ulcer. It was therefore decided to perform a posterior gastro-enterostomy. After opening the stomach its interior was explored with the finger. No definite bleeding-point was recognized in

the ulcer. The communication between the stomach and the intestine was then completed with silk stitches. Before closing the abdomen about two pints of saline fluid were introduced into the peritoneum. During the first 24 hours after operation rectal injections of saline fluid were given every 4 hours and frequent nutrient enemata, which were all retained. The foot of the bed was raised. Although she continued to vomit bile-stained mucus at intervals there was no further loss of blood. Flatus was expelled in the evening. On the 12th she was better, though there was still sickness occasionally, but this became less frequent when the foot of the bed was lowered. On raising the head of the bed vomiting entirely ceased. On the 13th beef tea and peptonized milk were given per os. Recovery was uninterrupted.

Medical Treatment of Chronic Tuberculosis of the Intestine.

At the Clinical Society Mr. A. W. Mayo Robson read an important paper on this subject. He observed that whatever might be the views regarding the treatment of acute intestinal ulceration, surgical treatment is generally advisable in chronic intestinal tuberculosis. He related 7 cases (one male and six females) in which he had operated with only one death. In 2 cases the adhesions to adjoining parts were very intimate, in the others the affected parts of the bowel were quite free, thus rendering operative measures easy and simple. In 4 cases he employed his decalcified bone bobbin as a temporary splint over which to apply sutures. The physiological rest to the diseased parts secured by short-circuiting (as in one case) and by colotomy (as in another) seemed to answer so well that when the radical operation of excision involved serious difficulties or the patient was not in a condition to bear it he will not hesitate in future to be content with similar proceedings and then to trust to general treatment and hygienic surroundings to assist in the cure. If in the future operative treatment be thought advisable in acute cases he anticipates that short-circuiting the diseased area will be found to be the more useful procedure, as it is the easier and safer, but experience alone will show whether the suggestions will prove of as much service in acute as they are in chronic cases. It is interesting that in 2 cases, in which tuberculous peritonitis coexisted with tuberculous ulceration of the intestine, the mere exploratory operation had not cured or even arrested the tuberculous process, but the radical operation of removing the principal focus of disease or the short-circuiting put a stop to the tuberculous peritonitis and, so far as could be seen, cured the more diffuse disease. All surgeons must have the experience of curing tuberculous peritonitis by simple abdominal section with or without drainage, and probably many of disappointment in cases in which the effusion had returned after a longer or shorter interval. He supposed that the explanation of these recurrent cases lay in the fact that the original focus of disease in the ovaries, Fallopian tubes, or bowel, had not been removed and again was the starting-point for a further effusion of the tubercle through the peritoneal cavity.

Correspondence.

Death from Chloroform Anesthesia.

MANITOWOC, WIS., Jan. 26, 1902.

To the Editor:—In reading over Dr. Bayard Holmes' paper on "A Report of a Death from Chloroform Anesthesia," I am surprised at the ungenerous stand the Doctor takes in regard to the anesthetizer. After stating, "It has been my practice to have a skilful person administer chloroform, even if it necessitated an untried and even inexperienced physician as my first assistant," he, a little further on, takes comfort in the fact that the anesthetizer in this case was a stranger to him and untried. Why should that fact soothe, rather than trouble, his conscience, since he neglected to follow his own rule? The anesthetizer being a stranger and untried does not prove him unskilful. Death from anesthesia may be due to improper administration, to an unfavorable condition of the patient, or to an unfortunate choice of the anesthetic. It has been proven again and again that ether narcosis is the safer, and chloroform is usually substituted because it is administered more quickly and pleasantly.

Physicians practicing in the smaller cities can not always call an expert anesthetizer to their aid, and they are obliged

to call on a brother physician, a student, a trained or untrained nurse or a layman to take his place. In emergency cases the anesthetic is often administered by the surgeon in charge, who at the same time is his own first and second assistant and trained nurse; and deaths from ether or chloroform are as rare in their practice as under the care of the trained anesthetizer and score of assistants in the large hospitals.

The best of men have lost cases from the anesthetic, yet they have not been censured unless it was proven that they were criminally careless. Why, then, in this case, where no carelessness has been shown, should the anesthetizer be given the blame, while the surgeon coolly excuses himself with the statement that that assistant was unknown and untried?

The Doctor evidently had not recovered from his agitation when he wrote that a physician who had once given ether should never be allowed to give chloroform afterwards.

Yours respectfully,

WM. G. KEMPER, M.D.

Appendectomy—Surgical History.

CINCINNATI, O., Jan. 24, 1902.

To the Editor:—Will you kindly publish the enclosed letter bearing on the subject of early operation in appendicitis, and oblige,

Yours respectfully,

B. MERRILL RICKETTS, M.D.

"FT. WAYNE, IND., Jan. 21, 1902.

"Dr. B. Merrill Ricketts, Cincinnati, O.

"Dear Doctor:—The enclosed clipping from THE JOURNAL of the American Medical Association was sent me this morning by my son, Dr. George C. Stemen, of Denver. ["Appendectomy—Surgical History," Page 46, this Volume.] I had overlooked this in reading THE JOURNAL.

"In regard to my case, I will say that on April 22, 1887, I was called in consultation to see a man said to be suffering from general peritonitis and called "perityphlitis." There was every indication that the man would die, and I said that if he would consent, I would operate on him. He not only consented but requested that it be done. I made the operation and found a large quantity of pus and a necrosed appendix almost detached. I removed it and drained, and the patient is living to-day. You misunderstood me when I met you at Lima, as to it being 1884; it was 1887. The gentleman I operated on is A. B. Nickey, who lives at Princeton, Ind., and is in good health.

"I thank you for mentioning my case. I am not much concerned as to whether I made the first operation, but I certainly made one quite early in the history of this operation.

"Respectfully yours,

"C. B. STEMEN, M.D."

The A. M. A. as Basis of Reciprocity.

CHATTANOOGA, TENN., Jan. 21, 1902.

To the Editor:—I can not just at present go into a detailed consideration of defense of the proposition, but I wish to heartily endorse the suggestion made by Dr. Skelly in the last issue of THE JOURNAL, that membership in the American Medical Association be made the basis of reciprocity for license to practice between the various state examining boards.

With this as a foundation idea it seems to me that it is possible of elaboration so as to practically apply to this vexed question how to bar quacks and impostors, while at the same time recognizing intelligence, experience and probity towards license for practice throughout our common country, with as little of examination as may prove reasonable in compliance with laws as now existent or contemplated.

At some future date I may find opportunity for further argument on this point. At present I merely want to bring out further opinions upon the proposition, so that we may hear both sides of the question and ascertain how extensive may be the impulse to make this membership a basis for reciprocity, how practicable it is, what obstacles interpose, and how the examiners themselves receive the proposition. In a word let us "reason together" about the matter.

Yours,

E. A. COBLEIGH, M.D.

Tetanus Following Vaccination.

PHILADELPHIA, PA., Jan. 21, 1902.

To the Editor:—I will be greatly obliged to any of your readers who may have had or know of cases of tetanus following vaccination, if they will communicate with me concerning them. I am engaged in a critical analysis of such cases in the hope of determining their etiology, and desire to secure all the data possible.

Respectfully yours,

JOSEPH MCFARLAND, M.D.

Married.

GEORGE WESLEY BEATTY, M.D., of Brooklyn, N. Y., to Miss Caroline M. Steingester.

HARRY E. BURDETT, M.D., to Miss Nellie O'Gara, both of St. Paul, Minn., January 8.

HERBERT BACON, M.D., to Miss Mollie Prouse, both of Bloomville, Ohio, January 19.

DWIGHT CALKINS, M.D., Battle Creek, Mich., to Miss Marjory E. Ryder, of Pittsburg, Pa.

CHARLES E. CONGDON, M.D., to Miss Anna Ramsdell, both of Nashua, N. H., January 16.

JAMES H. DAVIS, M.D., Seyppel, Ark., to Miss Inus Bishop, of Belton, Texas, Dec. 23, 1901.

WILLIAM S. BEATY, M.D., to Miss Estelle Bonner, both of Vineyard, Ark., January 29.

WILMER ADAMS, M.D., Wye Mills, M.D., at Baltimore, to Miss Mamie R. Gould, January 15.

HENRY T. NORMENT, M.D., Anthoston, Ky., to Mrs. Virginia Norment, Henderson, Ky., January 16.

HERMAN S. SPEAR, M.D., New Portland, Me., to Miss Evelyn Conant, of South Strong, Maine, January 1.

FREDERICK PHINEAS DRAKE, M.D., London, Ont., to Miss Ada Kibbee Wright, of Port Huron, Mich., January 15.

WILLIAM N. MCARTNEY, M.D., Fort Covington, N. Y., to Miss Caroline Claghorn, assistant superintendent of the Lackawanna Hospital, Scranton, Pa., January 15.

Deaths and Obituaries.

Sylvester D. Bell, M.D. Western Reserve University, Cleveland, Ohio, 1874, formerly a practitioner of Butler, Pa., but for the past few years a resident of Arizona, a member of the Medical Society of the State of Pennsylvania and of the American Medical Association, died at his home in Tucson, January 14. He was a presidential elector in 1892, and had held several responsible territorial appointments.

Frederick Gundrum, M.D. Miami Medical College, Cincinnati, 1868, who had practiced for several years in Indiana, going thence to California on account of his health, died at his home in Riverside, January 13, from asthma complicating la grippe, after an illness of three days, aged 57. He was a member of the American Medical Association.

Kingston Goddard, M.D. University of Pennsylvania, Philadelphia, 1860, a contract surgeon in the Civil war, and thereafter for many years a practitioner of Philadelphia, coroner, and member of the Board of Education, who retired from active practice several years ago, died at the residence of his son in Philadelphia, January 18, aged 62.

James Farrington, M.D. New York University, 1847, one of the oldest physicians of Rochester, N. H., died at his home in that place, January 18, aged 80. He was a member of the Strafford District and New Hampshire State Medical societies and had served as a member of the legislature, of the constitutional convention and of the governor's council.

John Brownrigg, M.D. Jefferson Medical College, Philadelphia, 1851, formerly a surgeon in the Confederate service, one of the most prominent physicians of Mississippi, and a resident of Columbus, died January 21, at Mullanphy Hospital, St. Louis, where he had been under treatment for a long time, aged 72.

Warren Montgomery Sweetland, M.D. Rush Medical College, Chicago, 1848, for twenty-five years a resident and practitioner of Highland Park, Ill., who retired from active prac-