

patients are mostly Hebrews, gave it as his opinion in a paper read before the American Surgical Association, that this race frequently suffered from rectal affections. He expressed the same opinion to me personally.

Fistula in ano is just as common, or nearly so, in the colored race as in the white. An analysis of 43 hospital cases shows 33 in whites, 10 in negroes; normal proportion of colored to white, nearly 1 to 3. The liability of the negro to tuberculosis explains his being more frequently affected with fistula than piles. Twenty-seven of the series were males and 16 females.

Age.—The first decade, as in piles, furnishes no cases; the second but 5 cases, aged 13, 16, 17, 18 and 19 respectively.

	Cases.
The third decennium furnishes	12
The fourth decennium furnishes	10
The fifth decennium furnishes	4
The sixth decennium furnishes	11
The seventh decennium furnishes	2

Fistula is undoubtedly more fatal in the colored race. Of the fatal cases reported to the Louisville Health Office during the past ten years, there were nearly twice as many deaths in negroes, although the normal proportion of colored to white population is only 1 to 4. This would indicate fistula in the negro to be nearly eight times as fatal as in the white. The excessive mortality in the colored race can be explained by their greater tendency to tuberculosis, sepsis and syphilis.

ACUTE INTESTINAL OBSTRUCTION.

Omitting congenital malformations as a cause of obstruction, we have first, invagination or intussusception; second, impaction of foreign bodies, notably gall-stones; third, volvulus or twisting of the bowel upon its axis, said to be due to elongation of the mesenteric attachment of the gut; and fourth, internal strangulation either due to an inflammatory band, a Meckel's diverticulum, or a protrusion of the gut through some internal opening. I have only chosen to consider acute obstruction, as it would seem to have a more direct bearing upon the questions of age, sex and race.

Intussusception.—Intussusception causes at least one-third of all cases of acute intestinal obstruction. According to W. Brinton, who analyzed 12,000 post-mortem examinations, intussusception causes about 43 per cent. of all cases. Leichtenstern and Fitz place the figures at 38 per cent., others place them as low as 30. Intussusception is *pre-eminently* an affection of *infancy and early childhood*. L. Emmett Holt has collected 385 cases of intussusception in young children; 141 were under six months old, 89 between six and twelve months, 32 between the first and second year, 96 between two and ten years. It will be seen that considerably more than one-half of these cases occurred within the first year. It was encountered more frequently in males than in females—174 against 94. In adults intussusception is said to be more common in women than in men (Park's "System of Surgery"). At least one-half of all cases of intussusception take place at the ileo-cecal junction. Of the remaining cases twice as many will occur in the small intestine as in the colon.

Impaction of foreign bodies.—Foreign bodies, hardened feces, and especially gall-stones, may occasionally cause intestinal obstruction. From statistics, which I have carefully examined, it would seem that

this will explain about one case in fifteen of intestinal obstruction. I have seen two cases caused by impaction of enormous gall-stones, both in elderly subjects (white) and in females. Occasionally an instance will be met with in a child who has swallowed foreign bodies. Cases due to fecal impaction are usually in elderly subjects, a decided preponderance being females.

Volvulus.—Intestinal obstruction due to volvulus is comparatively rare. It nearly always occurs after middle life, frequently in elderly people, and is three to four times as common in men as in women. Elongation of the mesentery, which is supposed to act as a cause, may be congenital, but is usually exaggerated late in life as a result of prolonged traction, therefore explaining the relative frequency of this affection in elderly subjects, just as hernia is accounted for in the same way.

Internal strangulation.—This variety of intestinal obstruction is the most frequent of all. It may be caused by a Meckel's diverticulum, inflammatory bands, retroperitoneal herniæ, prolapse of the intestine into an abnormal pouch, or be a form of hernia. An intussusception is closely identified with the first decennial period of life, and volvulus with elderly subjects, this variety is associated with those between the two extremes of life. This is, as we might expect, on account of occupation, exposure and the diseases to which we are liable during the active period of existence. In men it may follow appendicitis caused by a band constricting the bowel; in women it not infrequently follows pelvic inflammation.

Race.—Of 45 fatal cases of intestinal obstruction reported to the health office for the past ten years, 40 were white and 5 colored; 26 males, 19 females. This would indicate a mortality in the white race exactly double what it is in the black. (Normal population one to four).

White, male 23, female 17; color not stated 10; colored, male 3, female 2; sex not stated 1; total 56.

CHAIRMAN'S ADDRESS.

[ABSTRACT.]

Presented to the Section on Obstetrics and Diseases of Women at the Forty-ninth Annual Meeting of the American Medical Association, held at Denver, Colo., June 7-10, 1898.

BY JOSEPH PRICE, M.D.

PHILADELPHIA, PA.

In the early history of gynecology the real pioneers had not only the scientific knowledge to attain, but principles to practically apply, means and methods to adopt without the aid of precedents or the counsel of fellow practitioners. It has always been difficult to perfect and establish a procedure.

McDowell operated with a mob at his door. Nineteen and ten years before McDowell's operation, William Bainham did two successful operations for ectopic pregnancy. Doubtless the success of Bainham's operation greatly influenced McDowell and was inspiration in his own heroic and successful work. Yet notwithstanding this success there was a suspension of the operation for a quarter of a century. Not again was the operation resorted to until 1843. Then by John Light Atlee of Lancaster, Pa., and John Clay of Manchester, England. To the extent to which these pioneers carried their work, we have in our own work, without material change, followed their methods,

perfecting somewhat the lessons they taught and enlarging the field of their application. Ignorance and prejudice yet face us at every turn, repeatedly opposing from sources from which we have the least right or reason to expect it. The old conflict is not yet altogether dead, buried and out of sight and hearing. Those whose courage was great, motives worthy, were abused for throwing light into the darkness in which the great body of the profession groped.

To illustrate and somewhat contrast the spirit of then and now we let Dr. Atlee speak: "It is well known that from the earliest period of ovariectomy in Philadelphia down to the present time it has been my invariable custom to invite members of the profession to witness the operation, in order that they might be able to form a proper opinion of its character and to judge of its propriety. There was not a prominent medical gentleman in this city that had not such an opportunity. It was a rare circumstance during the probationary stage of the operation for any one to accept the invitation cordially and gratefully. Some did so coldly, as if conferring a favor upon me, others politely declined, others positively refused and emphatically condemned the operation, while others took the invitation as an insult." "Gentlemen who were bold enough to witness the operation were even directly accused by their professional acquaintances of being *particeps criminis* in committing murder, notwithstanding these murdered patients recovered. Some high in the profession, against all ethical consideration, would call upon the patients who had finally decided upon the operation for the purpose of warning them against me and certain death. The colleges proclaimed fiercely against the operation as unjustifiable and criminal." Professor Meigs thus emphatically expressed himself: "I detest all abdominal surgery, I am free to say that I look upon all operations for the extirpation of the diseased ovary as not to be justified by the most fortunate issue in any ratio whatever of the cases, or in other words, not to be justified by any amount of success."

It is very good for men to be honest in their opinions, it is very much better for them, in spirit and in fact, to be right in them. Oliver Wendell Holmes has aptly said: "There can be no reason why the student of science should limit his attention to his specialty, though there is abundant reason why he should avoid any attempt to make researches over too wide a range of ground. His researches in his own special corner of science will lose nothing in value, but gain greatly, by an occasional survey of the work of others, only let him not pretend to take part in actual work in many parts of the field he surveys." All troubles to which women are subject, medical and surgical, are found within the field of the general practitioner. He should be a skillful diagnostician and should be competent to deal directly with many minor gynecologic troubles.

In the last decade the younger school of gynecologists have unfortunately lost interest or neglected plastic surgery. The great majority of them have been seized by the strange, inexplicable infatuation for the surgery of the peritoneal cavity.

The vital questions relating to plastic work have largely dropped out of the discussions of our societies, there are few recent contributions to our literature worthy careful study. Along this line we are slow in following the footsteps of the older specialists, the

compeers and followers of Sims. Sims, followed by his pupils, gave his plastic operations, methods and instruments, as yet not improved upon by modification or otherwise. All know the beautiful results following careful and successful work, and fully recognize that it is not work to be done by a mere apprentice to secure desired results. The reports of vesico-vaginal fistulæ run about as follows: "Two attempts at closure resulted in benefit to the patient, reducing the size of the fistula." Distressing conditions are not corrected, because gynecologists are not giving the subject the careful study its importance demands. My own experience can not differ widely from that of many others. In a recent series of cases I had four of vesico-vaginal fistula. They were sent to me either by their friends or physician. In each case there had been three or four attempts at closure, all failures. These failures were explainable from the certain premises that the patients had not been thoroughly prepared for operation by the common methods so fully detailed by Sims and his pupils. Operations for opening into the bladder, for complete laceration of the sphincter are failures in great numbers. Some operators seem to miss the sphincter absolutely. Careful training in plastic work is of more importance than in abdominal surgery. An apprenticeship in a gynecologic dispensary gives a practical knowledge of skin diseases about the external genitals, of parasites and growths, and also lacerations, that is rarely obtainable in private practice. Simple ovariectomies are easy, compared with the delicate, tedious and difficult work of dealing with mutilations where they are extensive, where we have lacerations of the urethra, perineum, bladder and cervix, or a very common distressing disorder, uterine displacement, which received prolonged and careful attention at the hands of the early and prominent gynecologists. Of late years the preparation of the patient and soft parts for operative interference has not been sufficient. Uterine displacements were treated successfully by simple methods by the early gynecologic specialists. Hodge, Sims, Gaylard, Thomas, Albert Smith and many others of equal prominence at home and abroad, corrected the displacement or put the uterus in the normal or desired position with some form of properly adjusted pessary. Displacements are quite generally shirked or neglected. The very common office attempt at local treatment and the correction of displacement is an error and about always a failure. Both office and the run-about treatment in the whole range of gynecologic disturbances are to be condemned. Women with uterine posterior displacements should be put to bed, uterus put forward, all lacerations repaired and a well-fitting pessary placed. Many general practitioners who make no pretense of special skill or knowledge, succeed beautifully in correcting displacements; this they do by putting the patient to bed and correcting the retroversion or the retroflexion by using one of the varieties of the Albert Smith or Hodge pessaries, with Gayland Thomas modification. The great, round, soft rubber rings are useless and harmful, but are in much too common use. The stem girdle pessaries are of but little value. All lacerations should be carefully repaired and posterior displacements carefully corrected before any of the usually adjusted pessaries are placed.

The rest treatment for the correction of displacements is the shortest, surest and most satisfactory. Anterior dressing of the uterus for a few days, with the

patient remaining at rest, in the Sims position, favors a very speedy recovery.

It should not be taken that there are no risks associated with these mechanical appliances. Early in the history of the use of the pessary there were numerous accidents. I have removed them when very careful dissection was required, when the patient had worn them for ten or twelve years and had lost all knowledge of their presence. I have found them deeply buried and the patient dying. No great skill but great care is to be exercised in their application. Men familiar with placing them get good results, and rarely have accidents. The statistic records of accidents have a warning in them. An eminent physician has published an analytic monograph in this relation and tabulates results as follows: "Twenty-three cases of perforation of the rectum by the pessary; 20 cases of perforation of the bladder alone; 10 cases of perforation of the bladder and rectum; 1 case of ureteric fistula alone; 1 case of ureteric and vesico-vaginal fistula; 1 case of perforation of Douglas' pouch (neither fatal); 3 cases of perforation of the vaginal wall, the extruding portion of the pessary lying in the pelvic connective tissue, and 6 cases of the entry of a vaginal pessary into the uterus."

This record sounds a warning as to the importance of care in the application of the pessary. There has been no very recent startling of the profession by the announcement that someone had invented a new pessary. It is to be anticipated that during the meeting of our ASSOCIATION there will be a very lively shucking out of new methods of procedure.

All we know of the physiology of uterine action compels us to regard the uterus and ovaries as the strongest links in the chain of woman's health of mind and body.

Be not deterred by false sentiment or the jealousies of those who would rather keep their patients in their own hands than see them cured by others from doing what we know to be our duty.

"Do we not all know by sad experience of the years of useless suffering that might have been spared, of lives that might have been saved, of the ruin of conjugal happiness that might have been averted, of material usefulness that might have been preserved had an accurate diagnosis been arrived at in the earlier stages of uterine disease and a proper line of treatment adopted.

"In prolonged disorders of the uterus, resulting in enlargement, hyperplastic deposits or a process of fibroses following on arrested involution, in those secondary pathologic conditions attending upon lacerations of the cervix, in deep erosions, in unrelieved versions and flexions, in tubal enlargements and displacements, and in chronic affections of the ovary, as sequelæ of pregnancy, we find not only these reflex conditions present, but more aggravated pathologic consequences and more serious disturbance of function." These are the mature opinions of MacNaughton Jones and other eminent English specialists and general practitioners. I strongly direct attention to this subject because it has not received the attention its importance deserves. It has had a few able and courageous champions who have had to contend against obstructions raised chiefly by members of the profession from motives which we will not attempt to analyze.

I am satisfied that many cases of nervous disorder could be averted or cured by early and careful atten-

tion to uterine and ovarian troubles and the examination of pelvic viscera. We can only clear away doubts and establish safe scientific methods by utilizing the lessons of the observations and clinical experience of men who are working among facts.

Our surgery is very much more than an art, it is also a science without limit, a science with no tolerance for obstructionists, no false deference for the venerable, that replaces the old with the better new. We are not accepting mere opinions for truths, we are demanding scientific and practical tests, that old knowledge shall pass the crucial test of modern experiment and analyses. We recognize that we have not reached the "last results," that there is enough we do not know to keep us from falling into a condition of inertia, to furnish us with extensive "happy hunting grounds." I could not refer to many of the evidences of our progress without raising controverted questions.

We have given and continue to give names to things we do not understand, we know little or nothing about. We have cancer, typhoid and puerperal fever, they are names for conditions; there we are estopped; finding ourselves face to face with the unexplained, we grope for the cause and remedy. Among the best evidences of our progress are our medical journals. They are largely to be credited with the scientific spirit, the earnestness of research diffused through the profession, they bring forward questions of direct and current interest, touch our every-day work, give those facts of our clinical experiences which constitute our best lessons, they index our progress. Our periodical literature has largely taken the place of our old text books. Our leading minds, where they have something to say, say it through our magazines, and give us the best they know. To the busy physician the JOURNAL is largely his literary world. The JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION speaks for us as an ASSOCIATION, it is our official organ, it represents our scientific spirit and activities, the results of our study and research. Through it the teachers in our colleges, the specialists and general practitioners speak. However able and enterprising may be the editor, the JOURNAL will not rise above the high-water mark of the scientific intelligence of the AMERICAN MEDICAL ASSOCIATION—the great representative body of the American medical profession—by its report of our work we will be judged at home and abroad.

In conclusion I can only make brief reference to obstetrics. It is gratifying to know that the mortality in child-bed has been greatly reduced; this is largely due, both in lying-in institutions and in private practice, to cleanliness of environment. In maternity cases it is in the great majority of instances dirt and meddlesome or unskillful instrumental interference that kills. To have skillful obstetricians, the teaching of our schools should be more thorough, theoretically and practically. Our students pay liberally for their advantages and should be dealt with liberally; every avenue to thoroughness should be open to them. The professor who teaches him obstetrics should know the science and art of his subject and how to teach it. As a rule the professor of obstetrics is not an enthusiast in his line, nor does he infuse interest and enthusiasm in the student; his teaching is largely perfunctory. He teaches one subject, or professes to, while he practices another. About all of them *want to be* gynecologists and

specialists. Some of them take to neurology, which requires great versatility of genius, the art to write poor poetry and indifferent fiction. There are ample facilities in our educational centers for practical education in obstetrics; hospitals, courts and alleys are open. The student should be given that which will enable him, when he goes home, to go to work and do good work.

ORIGINAL ARTICLES.

THE QUALIFICATIONS AND DUTIES OF THE MILITARY SURGEON.

BY LIEUT.-COL. N. SENN, U. S. V.

CHIEF OF OPERATING STAFF WITH THE ARMY IN THE FIELD.

Nearly five months of continuous service with the army in the camp and field has afforded me an excellent opportunity to make a practical study of the above subject. This time was spent in Camp Tanner, Springfield, Ill.; Camp George H. Thomas, Chickamauga, Ga., and the Cuban campaign, the time being about equally divided in the different places. The first four weeks were occupied in Camp Tanner, where I assisted in the capacity of Surgeon-General of the State in the organization of the State troops. This service brought me into closer contact with the National Guard of our State than at any time before. A physical and professional examination in which I took part brought out the shady as well as the sunny side of their qualifications. The result of my experience here convinced me that the average National Guard surgeon is a faithful doctor, with more than average professional ability, but, with few exceptions, lacking the necessary military training in performing satisfactorily his administrative duties. This is a part of his education that has been sadly neglected in the past and should receive more attention in the future. Very few States make provision for physical examination of the medical officers, consequently some of them have entered the service totally disqualified for participating in an active campaign. Two of the candidates for the volunteer service from the National Guard of Illinois were rejected on this ground. The four weeks' service at Camp George H. Thomas as chief surgeon of the Sixth Army Corps opened up a wide field for extended observations in making comparisons between the work done by the surgeons of the regular army and of the National Guard. The surgeons of the United States Army are all men of superior education, splendid physical development, and those who have been in the service for several years are well versed in the routine work of the Medical Department. However, in all matters pertaining to medicine and surgery the average National Guard surgeon more than holds his own. This superiority of the National Guard surgeon over his colleague of the regular army is no reflection on the latter; it is the natural outcome of circumstances, which made such a difference inevitable. The young army surgeon has to spend many years at small and often out-of-the-way posts, where the opportunities for clinical experience and intercourse with professional colleagues are necessarily limited. He naturally soon falls into the monotonous and routine work of the post life, with little or no inducements to continue his post-graduate, scientific and medical studies. When the time comes to pass an examination he wakes up from his lethargy suffi-

ciently to go through the different compends to prepare himself for the coming ordeal. He breathes easy after he has reached the major's rank, as this promotion forever closes the door of the much-dreaded green room. From now on he is in the line of slow promotion without any extra exertions on his part. He receives his salary and looks confidently for assignments to posts where he can spend the balance of his life in ease and luxury. He has reached a time in life when he feels that he can avail himself of the work of his subordinates without interfering with his emoluments or his position in social and military life. He is conscious of the fact that he has reached a rank and a station in life where it is proper for him to look to his assistants to do the drudgery which he had become accustomed to in the past, and begin to enjoy the life before him. It is different with the military surgeon taken from civil life. He emerges from the turmoils of family practice. From the day of his graduation he has tasted the bitter fruit of active competition. His work has been watched with an envious eye and subjected to sharp criticism by his neighboring colleagues, old and young. He felt from the very beginning of his professional career that success depended upon his own exertions. The average American practitioner is a hustler. He is willing to work night and day to gain a lucrative practice and the social position which goes with it. With few exceptions he knows that what he has learned in college is but the entering wedge to a comprehensive knowledge of the practice of medicine and surgery. He knows that our profession has become a progressive one. His college education tells him what is new today will be old tomorrow. He looks with pity on his colleagues, advanced in years, whose language and practice convince him that they have fallen into a dangerous rut. He reads the numerous medical journals, the great avenues of recent medical literature. He spends his scanty income in purchasing new books and instruments for scientific investigations. All requisitions are made on himself and are honored only by writing his own checks. He joins medical societies, large and small, and attends their meetings regularly. He listens intently to the reading of papers and discussions to increase his store of knowledge and returns to his limited field of action better prepared to battle against disease. He mingles freely with the members of his profession, always ready to absorb and digest new ideas. He makes frequent pilgrimages to his alma mater or some post-graduate school to familiarize himself with the most recent advances in medicine and surgery. Social life has no attractions for him; he has entered the profession for the sole purpose of becoming an influential and successful practitioner. This is the kind of material our National Guard surgeon is made of. No wonder he outweighs the professional military surgeon in practical knowledge required in the treatment of injuries and disease.

The exacting and often onerous duties of the military surgeon in times of war require special qualifications to prepare and fit him for his work. He is not only expected to be well versed in theoretical and practical knowledge of everything pertaining to the practice of medicine and surgery, but he must be endowed with qualities both of mind and body upon which he can rely when engaged under the most trying circumstances. In field work he has often to perform the most difficult tasks with very limited