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## SCARLET FEVER.

By DR. GEO. M. LAUGHLIN.

**GENERAL.** This is one of the common diseases we meet in general practice. A great many osteopaths do not do a general practice, but simply an office practice, and therefore do not come into contact very often with acute infectious diseases. But, as osteopathic practice expands in the field, we come into competition more and more with the medical practitioners, and get more and more of these cases. If we do a general practice, particularly in a country town, like Kirksville, for instance, you will have a great many cases of scarlet fever to treat.

Our success in the treatment of scarlet fever is very good. In fact, I think our success in handling acute cases of all kinds is more marked and satisfactory, if possible, than the handling of chronic cases. Acute practice is very satisfactory as a rule. Patients respond to the treatment nicely, and recovery is the rule in most of these cases.

**HISTORY.** Scarlet fever is a disease which has existed for a long time. Some of the older medical writers spoke about it, but not until the last two or three centuries has it been differentiated from measles. It has been known in this country for probably two or three centuries. The disease is common in all parts of the United States.

Scarlet fever especially affects children—it is one of the diseases of childhood. Very few grown people contract the disease, even if they are exposed to it, and have not had the disease in childhood. Probably only two or three per cent of the adults exposed to the disease contract it.

**Season.** The disease is most common in the fall and winter seasons, and most of our cases occur before the tenth year.  
**Age.** Really, the disease is more common before the sixth year—say between the third and sixth year. At any time up to the tenth year you find a good many cases.

**Etiology.** We do not know definitely the cause of scarlet fever. We know it is an acute infectious disease,—that is, we have every reason to believe that it is, because it is just like other infectious diseases where we do know the cause.

**Onset.** It comes on suddenly, with a chill, and elevation of temperature. Then there are symptoms brought on by the toxin, indicating that the disease is an infectious one—there is no question about it.

**Contagion.** Scarlet fever is highly contagious, probably one of the most contagious diseases we have. It is fully as contagious as smallpox, diphtheria or measles.

**Bacillus.** We do not know definitely what the infectious agent is. This disease has been studied a great deal by bacteriologists but nothing definite has been reached as yet. A number of investigators have found the streptococcus in the throat and blood in advanced cases of scarlet fever, and in post-mortem examinations they have found the streptococcus, but most of the investigators are of the opinion that the streptococcus is a complication; that it produces, in connection with scarlet fever, the toxic symptoms, and probably some of the other symptoms such as enlargement of the lymph glands, and sore throat. The rash is probably produced by the toxin of scarlet fever.

**Dissemination.** The disease is spread very easily, unless proper prophylactic measures are taken to prevent the dissemination of the disease in a community. If there is a single case in a neighborhood, unless that case is properly treated and properly quarantined,

all the children in the community may be exposed to the infection, although possibly only a small per cent of them take the disease. Probably less than one-third or one-fourth of those exposed to the disease will acquire it, because there are conditions necessary in the susceptibility of this disease, as in other diseases.

**Protection.** The disease is often spread by physicians who attend children with scarlet fever, and who do not properly protect themselves from carrying the infection; who do not wash their hands and faces after treating a case, who do not wear a gown of some sort to protect their clothing while treating the patient. It is criminal negligence for a physician to attend a case of scarlet fever, and then, without protecting himself in some way, go from one house to another, and treat other cases, because he is apt to carry the disease.

**Schools.** The disease is frequently spread in schools. A child goes to school with scarlet fever, and is not immediately taken out of school; he goes until he is taken down, and cannot go any more, and in that way the disease is frequently spread.

**Epidemics.** It has been recommended by authorities that schools be closed during an epidemic of scarlet fever, to prevent the spread of the disease. The reason is that scarlet fever is a serious disease, and the mortality is high, not less than 10% in any epidemic, and frequently higher than that in virulent epidemics; every measure possible should be taken to prevent the disease and to protect children not already infected.

**Disinfection.** The disease is also carried about by children going into a house where there has been a case of scarlet fever, and where the child is then well. It seems that the infection is very tenacious, and clings to the clothing, unless the clothing is properly fumigated and exposed to sunlight. It may cling in books and toys for some months, or even a year or more, so the necessity of destroying toys that children with scarlet fever have played with is very plain. All of the bed clothing, and other clothing in the room where the child has been sick, should be thoroughly fumigated with formaldehyde. If it is something that cannot be washed in boiling water, it is well to fumigate with formaldehyde. Articles of clothing that cannot be washed are hung up in the room, the room is thoroughly closed, and filled with formaldehyde gas for about twenty-four hours. That will destroy all of the infectious material that the gas can get to. Of course, if the clothing is folded up, the gas cannot reach it.

**Plain Room.** In the case of an infectious disease, you should not have any extra articles of clothing or furniture in the room where the patient is sick. It is better to have no carpet on the floor, and have only a plain curtain, a plain table and a plain chair. There is less probability of spreading the disease afterward.

**Double Infection.** This disease sometimes appears in connection with other infectious diseases. The theory has been advanced that an individual can have but one infectious disease at a time. It is generally true that the antitoxin of a certain disease, which is always produced when a patient has that disease, will hold the body immune from any other infection while it is in the system and acting. Occasionally we meet a case of double infection, as scarlet fever with diphtheria, where we find both the streptococcus and the Klebs-Loeffler bacilli. We also find scarlet fever sometimes in connection with smallpox, and in connection with chickenpox. We do not find it in connection with measles that I know of, but sometimes with erysipelas and typhoid fever.

These cases are extremely rare. I do not know as I ever saw a case of scarlet fever complicated by any of these diseases, although the books speak of these cases.

**Incubation Period.** The incubation period varies. What we mean by incubation period is the difference between the time of exposure and the time of the first symptoms. Usually the incubation period is just a few days, about a week, sometimes as much as twenty days. There are no symptoms, however, during the period of incubation. The first symptoms appear at the time of the invasion of the disease.

**Onset.** The disease is brought on suddenly. The child is feeling all right say to-day, and tonight is taken very sick. You will not know what the trouble is if you are called, unless there is scarlet fever in the neighborhood, and then you will suspect the disease.

**Chill.** The child has a chill as a rule, and then he gets sick in a very little bit. Perhaps the chill comes on at 8 o'clock or 9 o'clock in the evening, and he will vomit all that night and will not sleep.

**Emesis.** Vomiting is a more common symptom in the beginning of scarlet fever than in any of the other infectious diseases of children. It is practically always present, except in very mild cases.

**Headache.** The patient will have headache, and a bad feeling all over due, of course, to the toxin.

**Temperature.** The temperature goes up pretty high in scarlet fever—104 or 105 degrees is very common in cases that are severe, and the temperature stays up pretty well for several days. It does not begin to get much less until along about the time the rash begins to fade away; the temperature then goes down by lysis. After perhaps a week from the beginning, in an ordinary case, the temperature has disappeared, and the child is out of danger, except some complications may arise, which we will discuss a little later.

**Dry Skin.** In the early stages the skin is dry, hot and rough. The **No Perspiration.** child does not perspire to amount to anything.

**Eruption.** The first day we have no eruption. The eruption makes its appearance on the second day usually, sometimes on the third day.

**Character of Eruption.** In the beginning you will notice the roughening of the skin, little red places that look like goose flesh. In some cases you do not get them. Usually, however, you get a hyperemic condition; press your finger on the skin, and the spot will clear up, but comes back when the finger is removed. The rash becomes more marked on the second or third day. The first day it is not very plain, but reaches its height on the second day. It commences on the neck and face, and if you examine the body, you will find it over the chest. If it is a well marked case, you will find it all over the body, real scarlet.

This appearance is not due to inflammation. In bad cases there is some inflammation, but it is usually a hyperemic condition, there being no particular organic change in the skin, simply a congestion of blood which produces the rash. That is the reason it disappears when you press your finger on the rash.

**Sore Throat Swelling.** Now the throat commences to get sore, and sore throat in scarlet fever is one of the very worst symptoms we have to combat. I have seen cases where the throat would swell almost shut. The lymphatics and tonsils would swell up, and stick out more prominently than in a case of diphtheria. Some of the glands would get as big as a walnut, or even larger. There is difficulty in breathing, and there is a membrane in the throat. If it was not for the rash, you would say you had a case of diphtheria, except there is a difference in the membrane.

**Membrane Bacillus.** The membrane in scarlet fever, or any throat inflammation in scarlet fever, is due to the streptococcus. We always find it there when we make a swab, while in diphtheria we find the Klebs-Loeffler bacillus.

**Character of Membrane.** In diphtheria the membrane is tough, of grayish color and is a continuous membrane, all in one piece as it were, spreading over the tonsils and uvula, and sometimes into the trachea. You never have a membrane in the trachea in scarlet fever.

**Differentiation of Membrane.** The membrane is soft in scarlet fever, and is tough in diphtheria. It is a little darker color in scarlet fever than in diphtheria and there is apt to be a spot of it here and there. In scarlet fever we find the necrotic spots due to the streptococcus. It is very foul at that time, on account of the necrosis. In diphtheria we never have that, except late in the disease after the membrane has commenced to slough off, while in scarlet fever we have it early.

**Glands. Strawberry Tongue.** The glands are always swollen and big. That is one of the earliest symptoms in a severe case. If you find the lymphatics enlarged, sore throat, chills, vomiting, loss of appetite, eruption, strawberry tongue, etc., you have a case of scarlet fever. The tongue is coated at first, but clears off the second or third day, and gets very red—a typical strawberry tongue, which you will not find in any other condition.

**Diphtheria.** If the strawberry tongue is absent, the rash absent, there is sore throat with membranes, lymphatics enlarged, and the patient is toxic, the chances are that you are dealing with a case of diphtheria.

**Acute Tonsillitis.** Of course, it may be acute tonsillitis. The membrane in acute tonsillitis is more like that of scarlet fever, being patchy, and not so thick and tough as in diphtheria.

The membrane in diphtheria is due to the Klebs-Loeffler bacillus, and in scarlet fever and acute tonsillitis is due to the streptococcus.

**Desquamation.** The child has been sick two or three days, or a week or ten days. I have had cases so mild that we would not have known that the child had scarlet fever, had there not been other cases in the same house; just a little sick, and we could scarcely detect any eruption at all. Sick perhaps a half a day, or one day; loss of appetite, a little vomiting, and after that all right. Some

cases are so severe that the temperature lasts ten days, and the eruption is present for a week. The child is prostrated, and delirious with the high temperature. The throat is swollen up, way out on both sides, and there is difficult breathing. If a child contracts the disease from a light case, no matter how light the case may be, he is just as apt to have a severe attack as if he contracts it from a severe case.

**Character of Desquamation.** Desquamation begins sometimes the third day after the fever makes its appearance, and sometimes about a week or ten days. The skin commences to peel off, and the amount of desquamation depends upon the amount of the eruption. If the eruption comes out good all over, there will be a good deal of skin peel off. Sometimes it comes off in great pieces and almost a mould of the hand will slip off.

**First Desquamation.** On the throat is where the skin first peels off. Usually it peels off in little flakes—sometimes very fine flakes, as fine as meal, then again in pieces big as a ten cent piece, or twenty-five cent piece. Occasionally a whole cast of the hand or foot will slip off during the period of desquamation.

**Highest Contagion.** This is the time when the disease is the most highly contagious. The desquamated skin is light, and may be carried out through the window for half a mile, and infect children at that distance. This is unusual, but possible. The usual way the disease is disseminated throughout a community, is by the desquamated particles being swept out of doors, and a draft of air carrying them to neighboring houses, where they infect other children. So the necessity, particularly during the period of desquamation, of preventing any of this desquamated material from getting out of doors.

**Duration of Desquamation.** The desquamation will last for two or three weeks, sometimes for six weeks, depending upon the severity of the attack—the more eruption the more desquamation, and the longer the child is in getting cleaned off.

**Quarantine.** The child should be quarantined as soon as the fever makes its appearance, and should remain in quarantine until he is thoroughly cleaned off, until the desquamation is complete, and that, in any ordinary case, will be not less than six weeks from the beginning to the end. Perhaps in milder cases he may be cleaned off in three weeks.

In most cities no patient is dismissed from quarantine short of six weeks, and in this way the spread of the disease is largely controlled.

**Recession of Swollen Glands.** During the period of desquamation, the glands that were formerly enlarged during the time of temperature, begin to go down, and at the end of desquamation they are usually completely reduced. I have known glands to be markedly enlarged, and stay that way for many months; they may become infected and break down.

**COMPLICATIONS.** These are just about as serious as the disease itself. The mortality from the complications is almost as high.

**Death from Toxemia.** Where death occurs in scarlet fever during the first week or ten days, it is caused by the toxemia. That is the virulence of the infection produces a virulent toxin, overcoming the nervous system and causing death, the same cause of death as in typhoid fever.

**Heart involvements.** A common complication in scarlet fever is some form of heart complication. The most common form is endocarditis, but this is no more common than in other infectious diseases. Any patient with a toxic condition is subject to endocarditis, or inflammation of the lining of the heart. If it persists for considerable length of time, it is apt to leave a permanent deformity, producing what we term organic heart disease,—regurgitation, stenosis or something of that kind. It causes hypertrophy, and afterwards dilatation and degeneration of the heart muscle, resulting in a general dropsical condition and death finally.

**Lungs.** The lungs are sometimes complicated in scarlet fever, lobar and broncho pneumonia occurring as a complication, especially if the child is not well nursed. In order to prevent this complication good nursing is usually sufficient. If the child is in a good bed in the early stages, has good care, plenty of air in the room, good ventilation and good bed clothing, proper baths, proper foods, and does not catch cold, the chances are that he will not contract either broncho or lobar pneumonia.

If the child is poorly located in a family where there are a number of children, poor accommodations, and very little help, we sometimes get this complication. Of course it is a serious complication, and is apt to be fatal.

**Kidneys.** The most common complication is nephritis. That is, acute nephritis more frequently follows this than any other infectious disease. It seems that the toxin of scarlet fever has a special affinity for the kidneys, and this acute diffuse inflammation of the kidneys takes place in a large per cent of cases of scarlet fever, par-

ticularly where the child gets up too soon and runs out of doors, more especially in a bad season, or bad time of the year. He is then almost sure to come down with nephritis.

This usually occurs in the third or fourth week after the disease makes its appearance. Of course by that time the child is over the fever. Desquamation is usually complete, and the patient is probably up and around the house, and if he is not watched closely he will slip out of doors. If it is a cold, raw day he is apt to get chilled. As a result, he is almost sure to contract nephritis. It may be very mild and never be noticed. He does not feel well, but the parents think it is the result of the disease, and pay no particular attention to it, and in the course of time the child will recover, even without treatment, if the attack is mild. If the attack is at all severe, the child will be taken down suddenly, will be prostrated, lose appetite and feel weak; the face will puff up from dropsy, sometimes the abdomen is distended and the feet swell, and you then have to deal with acute diffuse nephritis.

**Treatment Nephritis.** Put the child to bed and keep him there until all traces of albumen disappear from the urine. Put him on a milk diet—nothing but milk. Give him two-thirds of a glass of milk every two or three hours. After a few days he will want more, but do not give it to him. Give him all the water he wants. Encourage him to drink plenty of water, unless he is extremely dropsical. Do not allow him to get up under any circumstances. He must have complete rest, so there will be no waste of nerve force. Then treat him. Treat the back in the lower dorsal region chiefly, for there you will find the muscles tender and contracted. His back is painful, so treat him all along the back to loosen up his muscles. You should find bony lesions anywhere from the ninth dorsal to the first lumbar. There will be some abnormality in the bones there that you want to work on. After you have done that for a few days, the urine will be more in quantity, and there will be less albumen. You can cure practically every case under this method of treatment.

**Diet.** After the albumen has pretty much disappeared you can commence a little solid food, such as toast, soft boiled egg, or something of that sort, but let the diet be light for several weeks after that.

**Otitis Media.** Another complication is otitis media, or inflammation of the middle ear. In bad cases of scarlet fever the throat is very sore. The tissue becomes necrotic and the inflammation extends into the middle ear through the Eustachian tube. An abscess

forms in the middle ear, pus is generated there and has to come out. Sometimes it gets out through the tube, but not often, usually the ear drum is ruptured.

It is a difficult matter to examine the ear of a child, and sometimes we have to let it do the best it can.

**Prophylaxis** In the first place you can prevent it by treating the neck  
**Otitis Media.** osteopathically, and by keeping hot applications over the enlarged lymphatics. Use hot water, hot boric acid solution or antiphlogistine, they will probably keep the inflammation down. But if the inflammation gets into the middle ear it is apt to result in impaired hearing or deafness, or even mental alteration, if the disease extends through the bone into the meninges.

**Mental Alterations.** Some of you have no doubt seen individuals whose minds were impaired, giving a history of scarlet fever. That is the cause of it usually. Mastoid abscesses appear, or even meningitis, and may terminate in mental alterations which will be permanent.

**Otitis Media Treatment.** Frequently you can prevent mastoid abscesses, inflammation of the middle ear and meningitis; but if otitis media should develop, the ear drum rupture and discharge occur through the external ear, wash the ear out with boric acid solution, and put in cotton soaked in hot boric acid or iodoform. Keep the parts clean. That will assist drainage, and with neck treatment and application of hot antiphlogistine over the mastoid process, around under the ears, and over the neck, you can keep the inflammation down. Sometimes complete deafness and paralysis of the seventh nerve results from scarlet fever.

**Arthritis.** Another complication is arthritis. I saw a case in this town several years ago, which was not treated osteopathically, a boy about fifteen years of age who died from this complication. Death is not usually the result, but deformity. The boy had scarlet fever in a virulent form. He got over that, and during the period of convalescence was taken down with multiple arthritis. The infection of scarlet fever attacked the joints, and he had acute arthritis in various joints of the body.

**Necrosis of Joints.** In acute post-infectious arthritis, you know the inflammation is acute and severe, and unless the disease is checked early it terminates in necrosis of the joints. The joint breaks down, a number of them, and a mixed infection occurs.

The boy I mentioned died from septicemia, or infection of the blood stream with the streptococcus.

**Deformity.** Usually after a time the inflammation subsides in the joint, and the patient is left with a deformity of the hip, ankle, shoulder, or knee joint. This is a complication we have to look out for, and one we can treat successfully as a rule if taken in time. ✓

**Case Report.** About a year ago I was called to see a little girl ten years of age who had scarlet fever. About the time she was getting better, during the period of desquamation, and a few days after the fever had gone down, she commenced to complain of pain in the joints. She could scarcely move one leg on account of pain in the hip joint. No doubt that child was developing arthritis. I did not manipulate that limb at all—that would have irritated the joint. I kept it quiet, and put on hot applications to relieve the pain and this inflammation. We kept the hip covered with hot antiphlogistine, and then by treatment prevented this complication entirely, and after a few days the inflammation disappeared. I gave a purely spinal treatment, treated the abdomen some to keep the bowels open, but gave thorough treatment throughout the dorsal and lumbar region. Had no complications to amount to anything, and after a few days all pain disappeared.

**Adenitis.** Adenitis, or chronic inflammation of the lymph glands particularly of the neck, is another complication. This inflammation may persist after the disease, the trouble become chronic, the glands remain permanently enlarged, and ultimately break down.

**Post-Infectious Arthritis.** This is not the only form of arthritis which occurs following scarlet fever. It also follows other infectious diseases, particularly pneumonia, typhoid fever, sometimes measles, and occasionally some of the other infectious diseases. It more often follows pneumonia and scarlet fever than any other infectious disease. It is acute inflammation of the joints, usually resulting in the course of a week or two in suppuration, unless the process is stopped; later on in degeneration and destruction of the joint, and permanent deformity.

We have had a good many of these cases to treat—I do not mean in connection with scarlet fever, or immediately following, for we are usually able to prevent this complication by proper treatment and care, but a great many of these cases come to us in a deformed condition, and apply for treatment for correction of the deformity.

**Case Report.** We treated a little girl here several years ago whose condition was very bad. She gave a history of scarlet

fever, and during the period of convalescence she had multiple arthritis. Almost every joint in her body was attacked with acute inflammation; in most of the joints it had gone to suppuration, parts of the joint tissue were destroyed, and the child was left in a deformed condition. The spine itself was not attacked, but the hip, knee, shoulder, elbows, wrist and even the large articulations were more or less deformed.

In the first place, on account of the inflammation in the jaw, it had been left almost without motion. She could only get her mouth open wide enough to insert a pencil between the teeth, and had very little motion in the jaw. That limitation of motion was due to the fact that the inflammation in the articulation had been quite severe; the bone had enlarged as a result of the inflammation, although it had broken down—(there was no suppuration here) and fibrous tissue formed around the jaw, so there was partial ankylosis with enlargement of the articular surface—thickening. There was no inflammation nor pain when she came here, simply the results of the disease.

We had to attempt to break up the tissue and increase the amount of motion. This we did in the course of a year or two to considerable extent. Never, however, were we able to completely correct the jaw, but improved it a good deal by manipulation.

That was only one feature of her bad condition. The shoulders were stiff—fibrous ankylosis there, but this was improved by treatment. The wrists were rigid, but the principal deformity existed in the hip joint.

The hip joints are the ones that are most affected in arthritis, most commonly, and most seriously. I will tell you why the deformity is greater there than in any other part of the body. It is due to the fact that the weight of the body is borne by the hip joint, and if the child gets up too soon and walks about, the weight of the body will cause degeneration in the hip joint. That is the reason why in tuberculosis of the hip joint we have more deformity than in the knee or shoulder. There is no weight on the shoulder, and when it is sore the arm will not be used. It is quite different with the hip. Unless the hip is given absolute rest, the degeneration is apt to be more marked than in any other joint of the body, except the spine in tuberculosis, where the spine bears the weight of the body.

**Ankylosis** Sometimes we have fibrous, and sometimes bony ankylosis. By bony ankylosis we mean that the bones grow together; the head of the femur and the acetabulum become one bone as it were, no dividing line between the two at all. During the course of the disease, when the inflammation is acute, the bones become rarefied and get quite soft. The tissues between the

bones, the synovial membranes and cartilages, are entirely eroded and disappear. That leaves the soft bones in contact. They are much inflamed, and there is an exudate which comes in connection with this inflammation. Finally when the inflammation subsides, this exudate becomes organized. First it forms fibrin, and afterwards this gets like a callus. It is soft from the exudate, and after that the bone is formed, and then you can do nothing for it by treatment.

**Breaking up Ankylosis.** It is not wise to attempt to break up bony ankylosis by manipulation, because you are apt to break the bone in the wrong place, especially in the hip joint. If you attempt to use great force, as we sometimes do in fibrous ankylosis, you are more apt to fracture the neck of the femur than to break up the ankylosis between the head of the bone and the acetabulum.

**Resection.** If the deformity is bad, if the ankylosis leaves the limb in a bad position, as in a flexed position, rendering the limb useless, it is then wise to have a surgical operation. The joint is opened, the bone is cut in two—resection of the neck of the femur is made. That is, the neck of the femur is sawed in two and the limb extended, not completely, but almost. The patient can then use the stiff leg some.

In the case of the little girl I spoke of, there was a bad degeneration of the hip joint, the acetabulum and head of the femur were in bad condition. The acetabulum in this case in one hip was eroded, and the top part of it had disappeared. The epiphysis of the head of the bone had disappeared. This allowed the hip to slip up, and made it look like a dislocation. Parts of the capsular ligament were still intact, which caused the limb to turn, in which made it appear more like a dorsal dislocation.

**Deformity Improving of** After a deformity once takes place we cannot prevent it. Sometimes we can improve it by cutting tendons, breaking up adhesions, etc., but it is simply improvement of a bad condition, and does not cure it.

**Deformity prevention of** A great many of the deformities result from tuberculosis or something of the kind, and in many the deformity could not be prevented. We cannot prevent deformity in all cases. We can prevent it in a large per cent of cases.

**Complete rest of Joint.** Remember the general principle of treatment of joint inflammation, the one I always impress upon students

because of its importance—**do not manipulate a joint which is acutely inflamed**, or when there is chronic inflammation, if it is tubercular. Do not manipulate—give it complete rest.

Relieve the limb of weight bearing. Remove all irritation to the hip, so as to allow the inflammation to become quiet.

**Differential Diagnosis.** The differential diagnosis in scarlet fever is not difficult as a rule. We know that scarlet fever comes on suddenly usually epidemic, several cases in the neighborhood, and that helps in making a diagnosis.

**First Symptom.** The first symptom is headache, which is followed by vomiting, the child getting real sick. He will not sleep much the first night, and vomits every little while.

The temperature is high the next day. The first evening or the following day the rash breaks out. It is a scarlet rash, beginning on the neck and face and extending over the body. It is not like the rash of any other exanthematous disease or eruptive fever.

**Measles.** The only thing that could confuse you at all is measles, but the rash is different from measles. It is difficult to describe the rash in either of these diseases so as to give you an accurate idea. After you have once seen a case or two of scarlet fever and measles, you will have no trouble in differentiating between the two conditions.

**Diphtheria.** First, we differentiate scarlet fever from diphtheria. These two diseases are probably the two most fatal epidemic diseases of childhood. One is about as bad as the other. Diphtheria has a little higher mortality, but a very septic case of scarlet fever is just as bad as a bad case of diphtheria. In the virulent form, the mortality is as high as in the worst case of diphtheria.

**Chief Difference Rash.** The chief difference between scarlet fever and diphtheria is that in diphtheria you do not have the rash which is peculiar to scarlet fever. In both conditions we have extreme intoxication, in bad cases. The intoxication is similar, and the constitutional symptoms are very much alike in the two diseases; but in scarlet fever the throat is frequently as sore as in diphtheria, just as swollen, and the lymphatics larger than in diphtheria. The membrane in diphtheria is more firm, tough, tenacious, and adherent than in scarlet fever.

In scarlet fever we have a spotted, necrotic membrane, which does not last so long as it does in diphtheria. In diphtheria the membrane is tough, looks fibrinous, almost opaque, and is continuous, commencing at one or two spots, and soon running together, forming one big patch. Not so in scarlet fever, it is patchy.

**Sepsis.** In sepsis we sometimes have symptoms similar to those scarlet fever. We have a rash in sepsis that looks much like the scarlet rash. It comes on with high temperature, pretty general

all over the body, and it is a difficult matter to differentiate it from scarlet fever, unless you know all about the symptoms, and the history of the case.

**Etiology of Sepsis.** We seldom have sepsis coming on acutely without something leading to it, some old abscess, or something of that sort. For instance, I have seen several cases of sepsis in children in cases of hip joint disease, old chronic cases, in connection with which we had chronic abscess of the hip. We have frequent chills, especially if there is an abscess, and profuse perspiration, the chills coming every day, or every other day. The temperature is high, followed by perspiration, with a history of some other disease preceding it, while a child may be well one day, and have scarlet fever the next.

**Erysipelas.** Erysipelas could hardly be mistaken for scarlet fever. It is usually local, that is the rash, and in connection with erysipelas we have swelling of the face, which we do not have in scarlet fever; pain in the region of the eruption, pain on pressure, and even when there is no pressure. The eyes commence to swell sometimes swelling shut, the scalp is tender on pressure, and the disease always begins on the face. There is no trouble as a rule in telling the difference between scarlet fever and erysipelas. Scarlet fever is almost always found in children, and erysipelas rarely. Practically all cases of erysipelas occur in adults. I never had a case of erysipelas in a child.

**PROGNOSIS.** This depends on a good many different things. It is a difficult matter to say of any disease that the prognosis is good or bad, it should be guarded.

Take pulmonary tuberculosis as an illustration. Asked the prognosis, some would say good, and some bad. The answer would have to be qualified. It is good in some cases and bad in others. It depends largely on the form, how early you get the case, condition of the patient, surroundings, and care of the patient.

So it is in scarlet fever. The prognosis in mild cases, with care is always good. You probably will have no serious complications. In a serious case, that is, in a virulent case where the fever is high, the throat very sore and the lymphatics greatly enlarged, even under the best of conditions the prognosis must be guarded, because you will lose some cases if you have enough of them.

I frequently have read a statement that such and such an osteopath has been in practice ten years and never lost a case. That means he has not had much business,—that is not a recommendation. You should



never turn a case over. Learn to assume responsibility. If you are protected by law, are a conscientious practitioner, and are satisfied that you can do as much or more than anybody else, take your cases through.

If you do a general practice you are bound to lose some of your cases. If you treat pneumonia, scarlet fever and diphtheria you are bound to lose some of them, for it is impossible to save them all. Some of your cases are going to die. It is not your fault at all. It is simply due to the fact, perhaps, that the surroundings are not what they should be, but the principal cause is that the infection is virulent, and the resistance of the child is low. These two factors taken together are the ones which produce death in practically all cases of infectious diseases—diphtheria and scarlet fever, typhoid and pneumonia. These four diseases are very severe, and if you treat a great many of them you will lose some cases. You will lose some cases of pneumonia because the vitality is low, and in spite of everything you can do the patient will succumb to the disease.

The prognosis as a general rule in scarlet fever is good. In mild cases, or medium cases the prognosis is almost always good. I have seen cases so mild that the child would be sick for only one day. Even in those cases, though, we must give the child proper care. They should be attended and watched along for sometime, because in some of these mild cases we are apt to have kidney complications just as marked as in severe cases. The other complications do not usually arise in mild cases, but nephritis is apt to occur in mild case. Some cases are so toxic that they die in three or four days. They may be treated several times a day, and everything done that can be, and yet they die.

**Prophylaxis.** In modern times more, or as much attention, is given to the prevention of disease as to its cure.

People do not pay enough attention to this. They go on in the usual way and pay no attention to surroundings and advice, and say, "Well, if I get sick I will have the doctor, and he will cure me," depending entirely upon the physician. Too many of us look on health and sickness that way. That is the wrong idea.

A great many physicians of late, and other public men, too, have taken up the question of the prevention of disease in the human race, and have accomplished a great deal, especially in the infectious diseases. A great deal can be done to prevent most all the diseases if people are educated up to it, and know what to do; but the most advance has been made in the prevention of infectious diseases.

Amongst those diseases where a great deal has been accomplished in the way of prevention is in typhoid, pneumonia (not so much in

pneumonia, as it is about as common as ever; but it is not epidemic, while typhoid frequently is, and a great deal has been done to stamp it out) smallpox, scarlet fever, measles, diphtheria, and so on, by quarantining the sick people, by disinfecting everything that has come into contact with the patient, disinfecting the stools, and all that sort of thing, so as to prevent contaminating the water supply, the air supply, etc.

**Management** I will tell you how a case of scarlet fever should be managed. I was called to a house last winter, and found a case of scarlet fever just beginning in a girl three or four years old. There were other children in the house, and we wanted to stop the disease right there, as it does not pay to take a chance. Of two children, one may pass through it all right, and the other may die. If you can prevent the other child from having it, it is your duty to do so. Ours is a serious profession. Too many people do not look upon this work as a serious profession—or any other profession for that matter. When it comes to the preservation of life, the prevention of disease, and all that sort of thing, it is a serious matter, and should be looked upon that way. I do not mean that the physician should go around with a long face; he should be cheerful and good natured and cheer people up, but he should realize his own responsibility.

**Isolation.** This child was sick with scarlet fever, so I immediately had the child confined in one room up stairs, and allowed no one to go into the room except the nurse, and did not allow her to go out. In order to protect the balance of the children, we put up sheets in front of the doors that led into the other rooms, and kept those sheets saturated with bichloride of mercury or boracic acid; wet them every once in a while, so if any particles of dust, or desquamated portion of the body came into contact with the sheet it would cling there, and not go into the other rooms. The food was taken up and put down at the door, the nurse took it inside, so that no one came into contact with the patient except the nurse, and the result was that we did not have any more cases of scarlet fever in that house. I kept that method up until the child was entirely well (she was sick about a week). I allowed her to go out after several weeks.

**Baths.** Another thing that is very important in the way of prophylaxis, is the care you give the patient to prevent the flying around of desquamated particles. As soon as the child commences to peel off, it should be bathed with soap and water all over the body. Just use any ordinary good soap, Ivory soap or something of that sort, and a good wash rag, and have the nurse bathe the child all over. The water and soap takes up all of the desquamated material.

Clean it off, and then, of course, the wash rag can be disinfected, and the water, before it is thrown out, can be disinfected with carbolic acid enough to destroy the germs.

**Oiling Patient.** Then, after the bath, the child should be oiled. Take any kind of good oil, or grease if you cannot get oil, and put just a little all over the body. That will hold the desquamated particles and none of them will get away. Leave the oil on, until the bath next day which cleans the desquamated particles off. Follow again with oil, and in that way none of the desquamated material is distributed around the house, or out of the window to blow over to your neighbor's and cause his child to be infected with scarlet fever.

**Debt to Community.** Mothers and fathers not only owe it to their own families, but they also owe it to the community to prevent the spread of disease by following this method. You will find that to be very good—excellent.

**Fresh air, Sunshine, Heat, carpet.** The room should be light and airy. You should keep the temperature at about 70 degrees, that is fully warm enough, 68 degrees to 70 degrees, not under 65. Let the sun come in. If possible, get a south room in the winter time, so there will be plenty of sunshine in the room, plenty of ventilation, and even heat. Have very few articles of furniture in the room; have no carpet, because a carpet will harbor germs for a long time, especially in dark corners where the sun cannot strike.

**Baths.** Then the child should be bathed regularly. There is a good deal of benefit in a bath in any case of fever. The bath that is given after the fever subsides is for the purpose of keeping any desquamated particles from flying about; but before the child pees off it is a good idea to give a sponge bath daily, and in some instances two or three times a day. If the temperature is high and the child delirious, a cold sponge bath is good. It will relax the muscular tension and increase the resistance of the nervous system. A cold sponge bath lowers the temperature and produces sleep, renders the nervous system less irritable, and is therefore a good thing to apply in all cases of high temperature, once a day anyway. Do not let the water be too cold if there is not much temperature, about 80 or 85 degrees. This should not be neglected.

**Diet.** The diet should be light. Never give any solid food in scarlet fever, and it is best not to give any for some days after the temperature subsides. Why? The tendency to acquire nephritis is not so great where the food is light. Milk is usually handy in every

community, and where it can be had, confine the diet to milk. It is just about what the patient wants. He will not want much of anything the first few days. A glass, or a half a glass of milk every two or three hours will be enough until he gets a better appetite. If the child does not like milk, protose can be tried. He is pretty sure not to like that; or, beef tea or soup of some kind, without any solid particles in it, or chicken broth.

**Bowel Treatment.** In all cases of this kind watch the bowels carefully. See that they move every day if possible. Right in the beginning of the disease it is not necessary to move them every day, but at least they should move every second day. Give good lumbar treatment, lower dorsal, and treat the abdomen gently. Commence very gently until you get the parts relaxed and then treat harder. If necessary, give an enema. After the child gets less toxic he will not have that trouble, but will always have constipation during the period of extreme intoxication in all infectious diseases, because the general nervous system is in a state of paralysis. Not complete, but partial paralysis. Nothing is active, everything lies dormant. That is but a temporary condition.

**Back Muscles.** In all cases of scarlet fever you will find that just as soon as the disease makes its appearance the back will be sore. All of the muscles in the back will become tender, just as tender as they can possibly be, and the least little treatment sometimes causes discomfort to the child in the beginning. The child usually enjoys the treatment after a day or two, so give a general spinal treatment, relaxing the muscles on both sides of the spine all along.

**Nervous Disorders.** The muscles being sore and contracted is evidence of irritability and irritation of the nervous system. The treatment has a soothing effect on the nervous system, renders it less irritable, tones it up, and stimulates its action toward the normal.

**Stimulation.** We do not stimulate the nervous system above normal. That you cannot do by treatment, nor can you inhibit the action below the normal in any condition; but if an abnormal condition exists, the manipulation will stimulate the nervous system toward the normal. That is the way we stimulate in this general treatment. In mild cases stimulate once a day, and in bad cases three times; spring the spine gently, and the child will soon enjoy it. Follow up sometimes with a sponge bath and rub with a towel. That is for the purpose of stimulating the bowels and kidneys, and improving the general nervous system.

**Throat Treatment.** Treatment of the throat is where you have your trouble. The throat is sore, the mouth is open, the child breathes with difficulty, the lymphatics are enlarged—where are you going to take hold? The child is lying there almost dead, you have to do something.

**Neck Treatment.** After you have given this spinal treatment commence and treat the neck very carefully. Leave the sore parts alone. Sit down behind the child, put your hands back of the sternocleidomastoid and manipulate gently in the back part of the neck; after you work awhile the muscles will loosen, and you can gradually relax the neck.

**Adjustments.** Do not try to set any bones, let that go until some other time, just relax the parts by gentle pressure. Keep that up five or ten minutes, and then gradually work down over the enlarged and sore part in front, but keep off of the enlarged lymphatics. Work very gently and do what you can.

**Necrosis in Throat.** There is necrosis in the throat and you want to clean that out some if you can. Small children object to spraying and on account of swallowing you sometimes have to let it go; their resistance often overcomes the effect of the treatment.

**Mouth Wash.** In larger children clean the mouth out two or three times a day with a mixture of listerine, peroxide of hydrogen and glycerine, one-third each. That makes a nice mouth wash, cleans off any necrotic material, and is not unpleasant to use. This should not be used full strength, but pour a little of it into water, say a spoonful into a half glass of water, and use as a gargle; or it may be used as a spray, using an atomizer or swab, in any event to the outer parts. The teeth and tongue should be cleaned also. Do not neglect this because it is important.

**Relieve Swelling.** To relieve the swelling around the throat, the best thing you can use I think, is heat. Some people prefer cold, and I have seen cold packs used successfully and have used them successfully myself in bad cases. Put it on and have it worn continuously until the child is convalescent. Have it changed several times a day,—cold pack around the neck and have it fit snugly around the jaw.

**Hot Packs, Antiphlogistine.** Another good thing, and one that I like best, is heat; either hot fomentations almost continuously applied, an hour or two at a time, followed by warm woollen cloths which remain around the throat until the next application, or

by the use of hot antiphlogistine. Antiphlogistine applied on a cloth about half an inch thick, heated to about 98 degrees and applied around the neck will stick there; you can wrap it up, and put other cloths on the outside.

That is the best we can do, and that usually—I would say in 95% of bad cases—will give you very satisfactory results.

**Summary.** In brief, give general treatment of the spine, keep the bowels open, clean out the throat, and then treatment of the throat, particularly to reduce the swelling. The general treatment of the spine is for the purpose of improving the general nervous system and eliminating the toxin—that is what causes the trouble any way, and the throat treatment is to reduce the swelling and to further breathing, etc.

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#### ONTARIO OSTEOPATHIC ASSOCIATION MEETS.

The ninth annual meeting of the Ontario Osteopathic Association was held in the Temple Building at Toronto, Ont., Sept. 8, '09. An interesting and profitable session was held.

Following is the program:

##### MORNING SESSION.

- 9:00—Meeting of the Executive.  
 9:30—Invocation. Business Session, Reading Minutes, Receiving Reports, Auditor's, Secretary's, Committees Appointed, Delegates to A. O. A. Council of Delegates, Legislative Council, Etc. Application for Membership. Business. Unfinished and New. President's Address,—(Review of the Year).  
 11:00—Clinics.  
 12:00—For the Good of the Science. (Informal Discussion). Science Circles, Dr. Heist. Recruiting, Dr. Millard. Frequency of Treatment, Dr. Gray. Methods of Publicity in Vogue, Dr. Walmsley.  
 1:00—Luncheon.

##### EVENING SESSION.

- 2:00—Osteopathic Mechanics. An Address by Franklin Fiske, A. B.; D. O., Professor of Philosophy and Mechanics of Osteopathy, American School of Osteopathy, Kirksville, Mo.  
 3:00—Costal and Interdependent Lessons, (Etiology, Diagnosis, Correction and Treatment,) by Dr. Fiske.  
 4:00—Methods that Save the Operator's Strength. A Demonstration by Dr. F. Fiske.

The next annual convention will be a two-days affair.

The year's officers were re-elected, and are,

President, R. B. Henderson, Toronto; Vice-President, Jas. S. Bach, Toronto; Secretary-Treasurer, Edgar D. Heist, Berlin; Assistant Secretary, F. P. Millard, Toronto; Trustees, H. C. Jaquith, Toronto; S. B. Detwiler, Guelph; J. N. MacRae, Galt.

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#### CASE REPORTS.

EUGENE F. PELLETTE, D. O.

A girl came into my office very much frightened, and with her face screwed around to one side. On questioning her, I found she had fallen from a horse a few days before, and hurt her arm, but had felt all right again in a day or two. However, her friends began to notice that she laughed only on one side of her face. Then she began to notice that she couldn't move the muscles on the right side of her face, close her right eye-lid, nor wrinkle her right eye-brow. She was twenty-one years old, weighed 185 pounds and was a country school teacher. Personal history good, previous to injury.

I found on examination the occiput and third cervical rotated to the right, a slight lesion of the inferior maxillary. I diagnosed the case as one of Bell's paralysis. After the first treatment, there was a slight improvement, and there continued to be an improvement after each treatment until she was completely cured, after seven treatments given in ten days. The lesions were completely reduced in that time. Treatment consisted, besides reducing the lesions each time, of thorough massage of affected muscles, and especially a loosening up of the structures beneath the ear, and behind the angle of the jaw on the affected side.

Another case which hasn't run along quite so smoothly, was in a woman of thirty, with three children, oldest five years and youngest one year old, had been lacerated, and was run down with work. She had aches and pains from the top of her head to the tips of her toes; almost every vertebra in her spine was in lesion, and so sore that she could not lie on her back. She groaned in agony when I lightly touched her back; I had her lie on her face, while with one hand hold of the trochanter of opposite side, and balls of fingers of other hand saddled lightly over the spines, I gently pulled the trochanter up and towards me. Even this gentlest of all manipulations pained her intensely.

I treated her every night for a couple of weeks with slight improvement, and then every other night, but it was a month before I could touch her spine without causing her extreme pain. At first I could not in any way relieve her, but now a light treatment will almost entirely relieve her of all pain. The case is still under treatment

A lady who had been given up by M. D's. came to me. She was forty-nine years old, married and children grown, weight about 160 pounds. She would have "spells" every few days, where, as she explained it, her whole left side would become numb, she would get cold, and almost smother from lack of breath; her heart would flutter and almost stop beating, there was an intense fulness over her chest, and she was somewhat dropsical. The M. D's. frankly told her they had no idea what was the matter with her, but they thought she was becoming paralyzed on that side. I found her heart in good condition.

Her ribs on left side dropped down from the fourth to twelfth, and the sixth, seventh, and eighth were partially piled on top of one another. Also the upper dorsal vertebrae were not in line. She had two or three "spells" always at midnight, the first week I treated her, for which I was called; always by lifting up the ribs on the affected side, she would become easy, and go back to sleep. She rapidly improved under treatment, which consisted of lifting up and separating the ribs of the left side, and lining up the dorsal vertebrae. All of the symptoms disappeared in a month, and she is apparently entirely well, although there is still some very slight difference in the ribs of the two sides.

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#### TYPHOID FEVER.

DR. GEORGE M. LAUGHLIN. (Concluded from last month.)

**PNEUMONIA.** This may develop in typhoid as a distinct and separate infection,—lobar pneumonia due to the pneumococcus; or you may have a pneumonia similar to lobar pneumonia due to the typhoid bacillus. This will produce pneumonia just like lobar pneumonia. Or, the streptococcus will produce lobar pneumonia, and you may also have the pneumococcus.

When pneumonia occurs in connection with typhoid, it makes the outlook more unfavorable, and sometimes it is difficult to detect. As the typhoid symptoms will cover up the symptoms of pneumonia, it is necessary in all infectious diseases to keep an accurate chart of temperature, pulse and respiration.

If your temperature is not just as you expect it in typhoid, and the pulse and respiration are more rapid, you want to look out for some thing else, and make a careful examination of the lungs. You can determine pneumonia by physical examination, and treat the case same as any other case of pneumonia.

**Broncho-pneumonia.** Another form of pneumonia which occurs with typhoid, and which is more serious than lobar, is inspiration

pneumonia. It starts with infection of the throat; the muscles of larynx become paralyzed, the patient cannot swallow water nor food, and any attempt to give the patient water or food results in getting some of either into the trachea. These carry infection into the tubes, the patient will get inflammation of the tubes, this inflammation extends to the bronchioles and tubules, and you will get lobular, or bronchial pneumonia. (bronchopneumonia). In cases of bronchial pneumonia there is great irritability all over the upper part of the lungs, and the patient is constantly attempting to cough and get something out of the throat. It is impossible for him to swallow. Respiration is rapid and the pulse high. This complication is a very bad one.

**ARTHRITIS** is not so much of a complication as a sequela. Following typhoid, pneumonia, scarlet fever and some of the other infectious diseases, we have in some of the cases a disease which we term post-infectious arthritis. It is the inflammation of the joints which follows typhoid. It occurs in about this order: first, follows scarlet fever; second, pneumonia; third, typhoid fever.

**Typhoid hip.** The hip-joint may get out of place. Inflammation of the hip comes on during convalescence, and the inflammation is due to infection of the hip-joint with the typhoid bacillus, as during the period of convalescence the bacilli are still in the system. That may terminate in suppuration and complete destruction of the joint, and sometimes of the soft tissues, and the hip may drop out of the socket.

**Typhoid spine.** Another form of arthritis which follows typhoid, aside from infection of the hip-joint, is sometimes called typhoid spine. This is inflammation of the spine following typhoid, due to the bacillus attacking the spinal joints. You never have suppuration in the spinal joints. The treatment for typhoid spine is rest, and gentle manipulation in the beginning—not enough to produce irritation. After a while you can give more vigorous treatment. You can cure these cases in practically all instances.

**DIFFERENTIAL DIAGNOSIS** There are three or four diseases that are somewhat like typhoid, i. e.: malaria, miliary or acute tuberculosis—(may have this latter and live only three or four weeks—quick consumption the laity call it) meningitis, sepsis and hidden abscess somewhere. **Malaria.** The difference between malaria and typhoid is in the character of the temperature, the initial chill and the grade of intoxication. Malaria is initiated with a chill. Usually the chill is quite marked, while in typhoid it is the rule not to have an initial chill. In malaria the patient may chill every day or every other day. In typhoid fever the

patient will not chill unless there are complications, as for instance, an abscess somewhere in the body. In malaria we do not have any prodromal symptoms.

**Miliary Tuberculosis.** Miliary tuberculosis attacks the lungs usually. We have small tubercles formed, and they are very numerous. In this disease the trouble comes on with elevation of temperature immediately. The patient is prostrated—sick in bed. This is usually a fatal disease, and does not run a course of more than four or five weeks. The temperature is high, and is not like that in typhoid; sometimes chills, and there is profuse perspiration. The temperature goes up pretty high, and while he is sleeping the perspiration runs off the patient, and wets the bed clothing all around.

By physical examination you can tell what organs are affected, whether it is the bowels or lungs, or where. We do not depend entirely on the physical examination to make a diagnosis in miliary tuberculosis, but depend rather on the history of the case. This is not a primary disease. Unless one has had tuberculosis previously in some other part of the body, or some other form, he will not have miliary tuberculosis. The most common cause is an old tubercular lesion in the bones—in the back, such as Pott's disease, or hip-joint disease. Always inquire thoroughly into the history of the case, and ascertain particularly if there has been tuberculosis of the bones in this patient, especially Pott's disease or hip-joint disease.

**Sepsis.** Sepsis is due to the formation of an abscess, or multiple abscesses in the body as a result of infection. You may have an elevation of temperature, there are chills—may be something like malarial chills—and profuse perspiration. These septic conditions usually follow some other infectious disease, like pneumonia or typhoid, or some disease of that kind.

**Meningitis.** Meningitis somewhat simulates typhoid fever, but in this we do not have prodromal symptoms as we have in typhoid. It comes on suddenly; headache is pronounced, delirium comes on right away, and the muscles of the back and neck are much more contracted than in typhoid. There is the tendon-jerk, the picking at the bed clothing, and athetoid movements. We do not have the "turning sign" in typhoid which we have in meningitis, and there is a difference in the abdomen. In typhoid the abdomen usually is distended on account of the formation of gas, but in meningitis we have the opposite condition, which is called "scaphoid abdomen." It is depressed. We may have these two diseases combined, and when we do the disease is very serious.

**Gastritis.** Gastritis sometimes gives symptoms very similar to typhoid. The patient does not feel well, has some temperature, headache and indigestion, and in the beginning it is difficult to differentiate this from typhoid. In gastritis you do not have the delirium, coma, twitching, etc.

**Blood Tests.** Blood test for leucocytosis in meningitis and sepsis may be made. You do not have leucocytosis in typhoid. In malaria you can often find the malarial parasite. In typhoid you find the bacillus typhosus after a week in the blood.

**TREATMENT.** In treating a patient for any condition, the physician should have some object in view, should have a definite purpose. In order to have a definite purpose it is necessary that you understand the condition of the patient. If you do not know what the trouble is, your treatment will not be specific.

**Objects.** The object one has in treating typhoid fever is to eliminate the toxin from the system. That is the primary object. Get rid of the toxin as rapidly as possible, and prevent its formation if possible. These two objects can be accomplished to a greater or less extent by good osteopathic treatment, proper diet and proper nursing. In attempting to eliminate toxin, of course, you take into consideration the organs of elimination, and try to stimulate them to their highest function,—kidneys, bowels and sweat glands.

**Kidneys.** In all infectious diseases pay particular attention to the kidneys. Treat along the lower dorsal and upper lumbar—you will always find trouble there in any toxic condition. You will have some nephritis in all forms of infectious disease. You will always find that part of the back in bad shape. If no bony lesions, you will find the muscles tender. By springing the ribs gently, and the vertebrae, you will often get a beneficial effect on the kidneys. It applies to diphtheria and scarlet fever especially, and to pneumonia.

**Bowels.** Then it is necessary to keep the bowels as active as possible by treatment, and by other agencies—not by drugs.

**Physic.** It is not a good plan in typhoid, even in the early stages, to resort to physic. It is not indicated, because it increases the peristaltic action of the bowels. This has a tendency to increase the inflammation of the bowels, and you should always remember that the thing indicated for that part is rest, no violent exercise or churning about. Keep the bowels active by spinal treatment. They are not active because the patient is full of toxin, and they are in a partially paralyzed condition. They lie dormant and have no peristaltic action.

**Spinal treatment.** Treat the lumbar region of the spine, and up through the dorsal region. Remove the contracture of the muscles, then use the enema. You can use this in the early stages, and if the fecal matter is hard use a soap enema. Make soapsuds in soft water, and use one or two quarts of that. It is perfectly safe in the early stages of the disease to use a high enema. This is also good to get rid of gas in the bowels. Later on, if the gas is quite troublesome, you can often relieve it by giving the patient a high enema, and adding a few drops of turpentine to the water. In very severe cases, where there is extreme distention from gas, after the second or third week, and you fear trouble from it, give this special attention. Also put hot fomentations over the entire abdomen, and in a couple gallons of water put in a tablespoonful of turpentine. This is for external application.

**Purpose of Treatment.** The osteopathic treatment consists chiefly of cervical treatment for the purpose of relieving the headache, and improving the circulation to the brain; dorsal treatment for the purpose of improving the nerve supply to the gastric tract, and lumbar treatment for the same purpose. Give good thorough treatment over the region of the kidneys for the purpose of stimulating excretion.

**Daily Treatments.** The number of treatments you give will depend largely on the condition of your patient. In mild cases one treatment a day may do. Ordinarily, you should see the case twice a day, especially if the temperature is running high and the patient is extremely toxic; if delirious better call often and watch the case closely.

**Abdominal Treatment.** In regard to the treatment of the abdomen in typhoid, there is considerable difference of opinion. The only reason we should not treat the abdomen is, that if the treatment is not carefully and properly given, or if considerable gas forms, it is possible by manipulation of the bowels that you will cause perforation. If perforation is apt to take place, and the bowels are full of gas, you may possibly produce the perforation by treatment. You should be very careful about manipulating the bowels. There is no more than the ordinary danger for the first week or ten days.

**Manipulating Bowels.** Gently manipulate the bowels during the first week because it helps to get rid of the fecal matter and tone up the bowels. It is a form of stimulation which is never followed by an inhibitory reaction. It is not like physic or chemical stimulation. Gently lift the bowels up out of the pelvis—get down deep on either side of the abdomen, and you will get a beneficial effect in that region. Later

on, if the patient is full of gas and pretty toxic, I would not advise you to do much work about the abdomen. After the tenth day, or the second week, leave it alone if there is a good deal of distention from gas, and the patient is very sick.

**Enemata.** I have handled cases without an enema, and in other cases have used the enema. I believe we get the best results where we use the enema daily throughout the course of the disease. It is not always done, but it can do no harm, and it appears to me to be a good practice. It cleans out the colon every day, and if there is an accumulation of gas it helps to get rid of it, and the patient will often absorb considerable water through the colon.

**Quantity** Have the enema at least a quart. In some cases use **Salt enema.** two quarts, but later on it is not advisable to use such a large enema. Sometimes only four or five ounces, but give it several times a day, especially if you want the water to absorb. Do not use soap in the enema after the first week, and sometimes instead of using plain warm water, use normal salt solution. Salt helps excretion. Where salt is absorbed it stimulates excretion of the toxins from the system, and that is one reason we sometimes in very bad cases, give a transfusion of normal salt solution under the skin. This is taken up in ten or fifteen minutes by the blood, and improves the quality of the pulse. Better give it per rectum if you cannot give it hypodermically.

**Nursing.** In typhoid the results of treatment depend largely upon the care of the patient. I would rather have a good nurse in typhoid than two good physicians—(that is, if I had to take my choice), or than an incompetent nurse and a good physician. A good nurse will know how to treat the patient, bathe him and give enemata. The real care of the patient is more important in typhoid than the treatment although we can accomplish something by treatment. You can assist Nature by treatment, but these other points in the care of a typhoid patient are really more important than the treatment.

**Diet.** The patient must have some nourishment, but only give as much as will be digested. If you overfeed it forms toxins from indigestion, and distresses the patient from the formation of gas. If you do not feed your patient at all, he will lose strength, and will not be able to overcome the attack of the disease. The mistake is more often made in overfeeding than underfeeding. The patient can get along for several days without anything to eat at all. Always look out for the eating in typhoid. The patient has no taste, as the tongue is thickly coated, and that same coat is throughout the entire alimentary tract. The secre-

tions from the glands are not normal, and there is but little digestion going on. Be very careful about the diet, and watch the results of the food.

**Milk.** Probably the best diet is milk, but milk sometimes cannot be taken. During the first week the patient has no appetite at all, and I would not encourage him to take nourishment. Let him go for a few days without much of anything to eat. Give plenty of water—all the water he wants to drink, but do not force the patient to eat too much. If he is left to himself he will not take too much during the fever stage.

**Quantity of Milk.** Milk is best, and we ordinarily give a glass two-thirds full about every three hours. As soon as that causes any trouble, any gas, or if there are any curds in the stools, that will show you there is indigestion. If patient is asleep do not disturb him to feed him. Sometimes it is well enough to put in a teaspoonful of lime-water in the milk.

**Pure Milk.** The milk should be fresh, and it should be pure milk. The freer milk is from bacteria, the less liable the patient is to suffer from indigestion. Give pasteurized milk if possible. The bacteria are what produce dysentery, etc. Certificated milk will keep for a week. It contains only about 100,000 bacteria to the cubic millimeter, whereas ordinary milk contains about 500,000.

**Protose** Give Protose in about the same quantity, or beef **Beef Soup** soup, where you strain out all the solid particles. **Buttermilk** Buttermilk can sometimes be used when the patient **Semi-solid Foods.** cannot eat anything else. Do not allow the patient under any circumstances to have a particle of solid food. For the first two weeks of convalescence the patient should be kept on a liquid diet, and then commence a semi-solid diet,—soft boiled egg or something like that. The patient will be very hungry, have a ravenous appetite, and will want to eat too much; if he does eat too much, he may die from acute gastritis.

**Bathing.** Instruct your nurse to give the patient at least one sponge bath each day—two is better, but at least one. If the temperature is high, a cold sponge bath should be given every now and then to reduce the temperature. If the temperature goes to 104 or 105, the nurse should get some cold water and give the patient a sponge. That will reduce the temperature perhaps one-half or one degree. Give it again in an hour or such a matter. You can often keep the temperature down pretty well that way. It not only helps to radiate heat, but the bath has a stimulating effect—makes the patient feel better and less nervous.

**Brann's Bath.** Most of the books describe Brann's method. It cannot be used very well in private practice. In hospitals it is quite successful. If at any time the temperature goes about 102.5 or 103 the patient is wrapped in a sheet and seated in a bath tub of water at a temperature of about 58 to 68 F.

**Disinfection of Excreta.** What the attendant should do, and the physician see is done, is that the stools are disinfected with chloride of lime or carbolic acid before they are buried. The **Bed Clothing.** bed clothing should be soaked in a 5% solution of carbolic acid. The attendant's hands should be washed in bichloride of mercury after every time the patient is attended. After the patient recovers and leaves the room, it should be disinfected with formaldehyde.

**Prevent Epidemics.** These are very important things to look after. The physician should not only look out for the case, but should look after the public health as well. It is only by disinfecting the stools that we can prevent an epidemic in any neighborhood where typhoid fever appears.

**Feeding per rectum.** We very seldom have to feed a typhoid patient per rectum. If you do, heat the milk to 160 F. before it is passed into the colon so that most of the bacteria are killed. It should then be cooled to about body heat before using. Give three or four ounces at a time.

\* \* \*

#### HOW TO OPEN AN OFFICE.

Probably there are about as many methods of announcing that you are ready for patients as there are practitioners. But, with all the numerous ways, there must be some ethical, dignified and effective way it can be done well in the majority of instances. Of course, it is realized that "circumstances alter cases," but we would appreciate an expression of opinion from our field members on the subject.

For instance, suppose you drop into Jonesville, population five to fifteen thousand, how are you going to announce in an ethical way your arrival, and the fact that you would like a few patients?

Again, suppose Jonesville has a population of forty or fifty thousand, will that alter your plan?

You might have the missionary spirit, and go where osteopathy was unheard of before your advent. What are you going to do about it? How are you going to acquaint the people with our science?

One of our boys who went into the missionary work last summer had quite a satisfactory practice worked up by the time summer was over.

On arrival he had printed a small pamphlet outlining osteopathy, and had these distributed where it seemed probable they might do some good.

We append a copy of the circular, and invite remarks on the question as a whole.

#### What Is Osteopathy?

"God has made man's body perfect; as long as the body is normal, health will reign."—Andrew Taylor Still.

"Osteopathy recognizes the human body as a machine—a self lubricating, self-regulating and self-restoring machine; one that has within it the power to manufacture and prepare all chemicals, materials and forces needed to build and rebuild itself, except when such power is interfered with by structural disorder. Osteopathy, therefore deals with the adjustment of perverted structural conditions thereby removing the cause of disease. Its purpose is to restore to a normal state the structural condition of the body, thus enabling nature to restore health through normal activity.

From its name it might be inferred that osteopathy deals only with the adjustment of bones. This idea is erroneous. The term structure includes muscles, ligaments and the various organs of the body, and in seeking to restore function, the osteopath endeavors to secure the proper adjustment of any or all of these parts to each other in regard to position, relation and size. A structural derangement maintaining functional disorder, in the language of osteopathy, is a lesion. It holds in abeyance the natural curative properties found in the body, and prevents nature from administering her own medicine. For example, a partial dislocation of the hip would be called a lesion. There would be pressure upon the sciatic nerve and its adjacent tissues and the disorder known as sciatica would result. The osteopath educated to detect such lesions, would relieve the pressure from the nerve by replacing the hip to its proper place. Thus by this simple manipulation a condition would be corrected that all the medicine in existence could not possibly reach.

Lesions may produce disease in various ways. As just illustrated, by direct pressure upon a nerve; by pressure upon an artery, rendering the supply of blood insufficient for proper nourishment to the organ which it supplies; by pressure upon a vein, which prevents the removal of all waste material in the system, thereby inducing tumors, goiter, etc., and by pressure upon the lymph glands, causing impoverishment of the organs supplied.

#### When and How Was Osteopathy Discovered?

Sixteen years ago there was but one osteopath in the world—Andrew Taylor Still. To-day there are more than five thousand osteopathic



physicians practicing in the United States, Canada, Cuba, Phillipines, England, Ireland and other parts of the continent. There are eight well equipped colleges of osteopathy in the United States, and their graduates receive legal recognition in forty states of the union. Osteopaths are employed as examining physicians by more than one hundred insurance companies. Their judgment is relied upon by numerous street railway and other corporations in large cities, in the settlement of personal injury cases.

The story of the phenomenal growth of osteopathy is interesting. Dr. Andrew T. Still, founder of the science, was for many years a medical physician in Baldwin, Kansas. Later he served as a surgeon in the Civil War. It was only after the death of three of his children, from spinal meningitis that Dr. Still became convinced of the utter uncertainty of drugs. Bowed down with grief, he renounced the use of medicine and began to seek for a more satisfactory method of healing. As might have been expected, such radical views did not meet with popular favor. The years that followed were beset with direst poverty for the doctor and his family. He was looked upon as a fanatic and referred to as "that crazy Still."

However, his courage was undaunted, and he began to study thoroughly the bony frame work of the body, the position and function of every ligament, nerve and vein. He determined the relations of every organ of the body. He mastered the mechanical principles underlying the operation of every joint and the function of every organ. Then began the study of the vaso-motors, the lymphatics, the blood and its effects in health and disease. Soon he began to try his new theories upon the suffering poor, and the few friends who still held faith in him. His cures were little short of miraculous, and slowly belief in his remarkable powers spread. People came long distances to be treated by him, and it became no unusual thing to see strong men as well as women and children embracing their benefactor as they departed for their homes cured of some terrible affliction.

In 1892, Dr. Still founded the American School of Osteopathy at Kirksville, Mo., and this is the oldest of the eight osteopathic colleges in the United States. Dr. Still is now eighty years of age, but is as active as a man of forty. He is still the nominal president of the college which he founded, and occupies a handsome residence within a block of the school. He is no longer called "that crazy Still," but is lovingly referred to as "The Old Doctor," and he has lived to see his life's ambition (Osteopathy) heralded throughout the world.

### Who Are the Friends of Osteopathy?

Naturally the friends of osteopathy are those who have been benefited by it. Mrs. J. B. Foraker, wife of Ex-Governor Foraker, of Ohio, says of osteopathy: "If osteopathy never does anything more than it has already done for suffering women, it has a right to exist." The Forakers employ an osteopath by the year, as does also C. Oliver Iselin of Cup defender fame. Theodore P. Shonts took an osteopathic physician with him to the Canal Zone when he was chairman of the Isthmian Canal Commission. The richest man of Iowa, F. M. Hubbell, who has been cured by an osteopathic physician, appeared before the Iowa legislature to urge a square deal for osteopaths. Paderewski employed two osteopaths during his recent American tour. Mrs. Hellen Delendrice, whose husband is termed "the merchant prince of the Dakotas," was so benefited by osteopathy that she appeared before the North Dakota legislature and by her personal plea secured the passage of a bill giving osteopaths a right to practice in this State.

These are but a few of those who have been benefited by osteopathy. Nearly every town and hamlet in the United States have in it people who owe a debt of gratitude to this science. What it has done for them it can do for you.

Osteopathy is successful in all curable diseases, and often relieves and checks incurable diseases. The osteopath successfully treats nervous disturbances, constipation and stomach disorders, ailments of the liver, kidneys and all other organs, diseases peculiar to women, catarrh, rheumatism, typhoid fever, pneumonia, scarlet fever, measles and all infectious diseases, chronic ailments of all kinds, etc."

# THE BULLETIN

OF THE ATLAS AND AXIS CLUBS.

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DR. NANNIE J. CHAPPELL, Axis Grand Chapter Editor

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KIRKSVILLE, MISSOURI, OCTOBER, 1909.



**Field Members.** Did it ever occur to you that if you fulfill your obligation to the Club that THE BULLETIN will at once be placed in the forerank of osteopathic publications?

A good majority of the most prominent men in the profession were active Atlas men at Kirksville, and while the fact that they were Atlas men did not of itself make them prominent in the profession, the Club association has a great tendency to broaden a man, and give him new ideas.

These men can be of inestimable help to us, who are preparing to enter the profession. Not only this, but they can do a great service to the members who have just entered their first year of practice.

By publication of your case reports, and articles on practice in THE BULLETIN, not only do local chapter members beget enthusiasm (without which study is more or less drudgery) but it extends also to some brothers in the field who may not have been so successful as you; and more, it helps put the Club in a position where students will appreciate its value and strive for membership.

Fraternity life is much stronger now than in former years of the school. While the Club is, and has been such that we believe we have so far been successful in obtaining for membership the most of the good men from each class, there undoubtedly have good men gone into other secret organizations.

The wide difference in purpose of the Atlas Club, as compared with the school fraternities makes real competition impossible; but no doubt we have lost some good membership by reason of students not being fully advised as to the aim and purpose of the Club.

Naturally, we cannot expect to procure all the desirable men from each class, but a liberal contribution of earnest articles from our field members to THE BULLETIN, will make it easier to maintain the standard of the Club.

Many of us did not know until after our initiation that there was such a publication as THE BULLETIN, and that the Club was strong enough to publish an exponent of osteopathy. It seems to us that it would not be at all a bad idea to let the prospective candidate know that such is the case, and loan him a copy.

Take the case of nearly any earnest student, who has broken former ties, and given up a lucrative or pleasant position to study osteopathy—who can doubt that such a student, apprised of the earnest desire of our membership to advance the common cause, shown the class of men we have sent into the field and their present interest in the Club as evidenced by articles in THE BULLETIN, would gladly avail himself of an invitation to join the Atlas Club, and share its benefits? Many of the brightest minds in the professions are ours, and no man need be ashamed to wear his Atlas emblem.

Now, brothers, rally around the old Club again. Your interests are ours, and ours are yours; our science is young, and we must all pull together.

As we must, in the nature of things, be divided into local and field members, THE BULLETIN is naturally the bond of union.

We look to our field members for counsel and advice, and we invite their thought and criticism in the conduct of the Club's affairs.

The editor would be glad to write each one of you personally were it possible, and solicit an article on your especial line or hobby, but as this is impracticable, consider this a pressing invitation to contribute.

We want THE BULLETIN to occupy its proper place in osteopathic journalism. The personnel of the Atlas field members is guaranty that this can easily and readily be done.

Will you help?

**Membership.** Apropos of the foregoing it has been suggested that the field members could render a valuable service to the Club in the matter of new membership in this way:

If you know of a young man leaving your vicinity to study osteopathy at Kirksville, look up his record if you are unacquainted with him and advise the local chapter whether or not in your opinion he would make a good man for Club membership.

If you know the man personally to be all right, write and tell us so, and we will make an especial effort to become acquainted with him.

Some of our field members have already started this, recommendations having come this month from brothers A. S. Bean of Brooklyn, N. Y. and R. W. E. Newton of Clay Center, Kans.

Its valuable to the Club—let others follow suit.

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**Life Membership Certificates.** The mailing list of THE BULLETIN has been compared with the books of the Pylorus since last issue, and some names dropped from the list for non-payment of dues.

Some of these dropped ones have evidently lapsed through oversight in payment of dues, and the Pylorus will have mailed statements of overdue accounts by the time this Bulletin is issued. Unless you remit promptly your name will be dropped from the mailing list.

This brings up the subject of Life Membership Certificates which as explained in September Bulletin is a means whereby a field member may make one payment to the Club and dismiss the matter of dues from his mind. Under the plan outlined you will receive THE BULLETIN each month regularly, and rest in the assurance that your membership in the Club has not lapsed.

Several of the Certificates have already been issued. Most of the brothers remitting wished to be accorded No. 1, but on resolution the Club accorded it complimentary to the Old Doctor.

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**Our Profession.** Osteopathy is a serious profession. Some do not realize this, and take the work in the same manner they would if they were taking a course in shorthand or bookkeeping, where another shoulders the responsibility.

One of our students called and treated a patient a few times, and finally saw that she was in a serious condition. "I can't treat you any more," he said, "for I don't want it said that any patients died on my hands."

There has been considerable said about the assumption of responsibility in serious cases, and it is the practice of many osteopaths to turn

their patients over to some other physician when the case looks as though it would terminate fatally.

We heartily accord with Dr. Laughlin, who told his Practice class last year that they could not expect to save all their cases. Some of them won't get well, and where we are protected by law there seems to be no valid reason why we should shirk a responsibility that belongs to us. Anyone not having stamina enough to see his cases through surely is not of the right stripe to make a true physician.

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**Excreting the Rash in Measles.** A Kirksville mother, in speaking of the slight illness of her little son, said he had never been quite so well since he had the measles last spring, at which time he was attended by an M. D. Then this:

"Doctor, is it true that the the osteopaths do not believe in letting the rash come out in measles?"

"No," he replied, rather startled at the remark and her evident sincerity, and wondering what was to follow. "They do not teach anything of that sort at the A. S. O. Dr. Laughlin distinctly states that we should aid in every way the appearance of the rash."

"I thought it was funny," she replied: "But Mrs. B. a friend of mine across town, told me that she has a neighbor who is an osteopath, and when his children had the measles last spring he said he was treating them in a way to keep the rash from coming out. This doctor told Mrs. B. that the rash would be excreted through the kidneys and bowels."

All of which goes to show, that we should not make any statements unless we have ample proof back of us.

Osteopathy was below par with this lady for the reason that a statement had been made by a third year student contrary to the opinion of both professional and laymen for many, many years. Had his claim been true, we would all gladly back his statement, but he only conceived the idea that he could eliminate all the toxins through the enuncitories, and had never demonstrated it; therefore he was at fault in announcing his theory as a fact until he had demonstrated it to be true.

People are watching us closely as a profession, and we must be careful, both as to speech and conduct.

\* \* \*

**"To Give, Not to Take."** I was talking to a patient one evening after having given a treatment, and the subject turned to our friends, the medical doctors.

"One fall, not a great many years ago," he said, "I was all run down and unfit for hard work, and was offered a position as driver and

stableman for our old family physician. He had an extensive country practice, and many miles I drove him during the course of my employment.

We naturally became quite intimate, as associates on the road will. After a couple of months, the doctor began to fail, and seemed to be gradually losing his strength and ambition, and used to doze as I drove him around.

I became worried as time went by and he did not seem to improve, so finally I said to him, 'Doc, you're running down awful fast, and I'm getting kind of worried about you. Why don't you take some of the medicine you are giving out to other people to cure them?'

The doctor sat up and looked at me rather queerly and said, 'That's to give, not to take.'

Doc, I replied, 'that settles it—you'll never give me another dose of medicine, and I haven't taken one since.'

\* \* \*

**"Call a Medical Doctor."** "We can do nothing for you—you better call a medical doctor," said a panicky student to a patient. We have been wondering ever since we heard of it why the student persists in studying a science which fails him at the critical point.

Don't be "weak-kneed," brothers. Give your patients the best you have in all earnestness, and stay with them. As one of our field members said, "If you cannot cure a curable case it's your fault—osteopathy is all right."

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**"One Side, One Dollar."** There are a good many ways to scale prices but here is the most ingenious one yet. A returning student tells it: "I had been told that a certain osteopath charged only one dollar per treatment in some cases, while in others he charged two dollars. This not being quite clear, and being of an inquiring mind, I called on the doctor as a patient, and told him my symptoms.

After the examination I asked the doctor what his charge would be for treatment and he said it would be two dollars. 'But, doctor,' I said, 'I understand you charge only one dollar per treatment in some cases.' 'Oh, yes,' he replied, 'but that is where the trouble is only on one side.' I treat on one side of the spine for one dollar, but if necessary to treat on each side of the spine it is two dollars."

\* \* \*

**Texas Closes.** The new ruling of the State Board of Medical Examiners for Texas, practically closes the state to osteopaths not already located there as there are comparatively few who hold a four year certificate

To be sure we were correctly informed, we made inquiry from the President of the Texas Board, who replied as follows:

"The change in our requirements only applies to osteopathic colleges. Our law exacts four courses in separate years. We have been accepting osteopathic applicants who complete their course within three calendar years and inasmuch this school enjoys equal privileges with other schools under the law they have thus been favored and to unify matters, beginning with June 24th, 1909, all osteopathic applicants for examination or who are given reciprocal credits will be required to show four courses in four separate calendar years. M. E. DANIEL."

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**They Like It.** We are indeed gratified at the reception accorded the September Bulletin. Many of the local chapter have expressed their appreciation of our efforts, while a number of our field brothers have taken the trouble to write and say they like THE BULLETIN.

Our old friend, Dr. P. W. Gibson, ('08), of Winfield, Kans., passes us a few compliments which we are too modest to print. Thanks, Gib., but why not send us a case report in addition? The boys would be glad to hear from you through THE BULLETIN.

Brother Ralph W. E. Newton, ('06), of Clay Center, Kans., expresses his pleasure on reading September Bulletin and says its the best yet.

Dr. Ida Ellis Bush, of Jacksonville, Fla., in sending in notice of her change of address, expresses her approval of our new cover for THE BULLETIN.

One of our brothers said last month's Bulletin was "best ever," and we would have to "go some" to keep to the standard it set. We intend to do this very thing.

\* \* \*

**A Hospital Incident.** Everybody loves a child—that is, every normal person does. Little Melvin Carns, of Grant City, Mo., age five, was brought into the surgical amphitheatre with Pott's disease of the neck to have a "jury most" fitted to relieve his neck of bearing the weight of the head.

Melvin confidentially told Dr. Laughlin that he had a nickle, which he showed in true Missouri style, and said he was going to buy a wagon with it.

At the close of the clinic some one started it, and in an instant the air was full of small coins dropping with a clatter in the cement floor. Dimes and nickles and coppers enough to buy a real red wagon were gathered, and Melvin is a proprietor now.

**Dr. Laughlin's Lectures.** The portion of the lecture on Typhoid Fever which we had to omit last month for lack of space, appears in this issue.

Many of our readers have commended us in inaugurating a series of lectures on Practice and we believe that they will be very valuable.

This month we present the first part of a lecture on Scarlet Fever. This scourge of childhood is ably handled by Dr. Laughlin, and should enable us, by familiarizing ourselves with his methods to successfully handle the majority of cases.

\* \* \*

**Freshman Reception.** The Freshman Class has been augmented since the opening of school, and now numbers 155.

The Junior Class on Friday evening, Oct. 8th, tendered them a reception in Memorial and North Halls of the school. The halls were very tastefully decorated with autumn shrubs, vines and branches, while in the center of the platform large white figures 1912 studded with small electric lights with blue shades, represented the class colors.

The Old Doctor made his appearance and was received with applause. He made one of his characteristic talks which was much enjoyed by all present.

After his remarks an interesting program was rendered following which punch was served.

A feeling of good-fellowship pervaded and the reception was declared an unqualified success.

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**The Bulletin as a Text Book.** "Sorry you did not print all of the lecture on Typhoid in the September number of THE BULLETIN" said a Junior not long after its appearance. "Dr. Laughlin is lecturing to our class on this subject and the Atlas boys are using THE BULLETIN for a text book."

\* \* \*

**Dr. Link Leaves Us.** Dr. E. C. Link, (Atlas, '02), for many years on the treating staff of the A. S. O. Infirmary has decided to engage in private practice.

Dr. Link has resigned and will travel around some before deciding on a definite location. He is much of a favorite in Kirksville osteopathic circles, and his absence will be keenly felt.

The Club has received many favors at the hands of Doctor Link, and our best wishes go with him.

In our September issue we inadvertently overlooked, in mentioning the student assistants, the name of W. O. Sweek, who is assistant in the pathology laboratory, and has charge of the Hospital Laboratory under Dr. Geo. Still.

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The new Constitution and By-Laws as amended by the Club, May 15, 1909, have been published in neat booklet form and are now ready for mailing.

\* \* \*

The Clubs should, and probably will issue a new directory of members shortly, as many changes have been made in the old one.

See to it that your Bulletin is properly addressed so that your name and address will appear correctly in the new issue.

\* \* \*

Saturday evening, Sept. 24, was regular open meeting for the Club members and friends.

Dr. R. E. Hamilton was the speaker of the evening, and gave a very interesting talk.



**Kerr.** Dr. F. Austin Kerr, N. S. XXII, '09 is out in the Mormon country. His address is 55 North Academy Avenue, Provo, Utah.

We had a breezy letter from him recently, in which, after passing us a bouquet on the September Bulletin, he says:

"This has been a strenuous summer with me, but am now nicely located. Provo is a charming little city of about 10,000 population, 47 miles south of Salt Lake City. The county has a population of 50,000, and I am the only D. O. The town is kept up by contiguous mines and fruit farms. It is also a school town. Brigham Young University with 1500 students, and a Congregational Academy with 400 students are located here. I have a choice location down town, and live about a mile away.

My main trouble is in getting people to know what osteopathy is. What the profession needs is publicity, of the right kind, of course. Many of my calls have been emergency because I was the nearest physician. Then occurs two grand surprises: (1) the spinal treatment and (2) the result. It is as astounding to the uninitiated as is the belief of those who think a drug swallowed can reduce a structural lesion.

In regard to the Utah law and the examination: The questions are about the usual State Board grind, but the examiners marked closely. I got 87.7% and while I was following Dr. Gerdine's advice to "try for an easy pass and let the catch questions go" I was disappointed at being under 90. I attribute it to the fact that the osteopathic member of the Board was a day late in getting in his questions, and so I got 64 out of 108 questions on the second day, and was rushed some. At that I was cool, felt confident and sighed for more worlds to conquer when I left the Board room!

In this state osteopathy is considered a school of medicine, and my license reads to practice medicine and surgery so I have plenty of legal protection.

There were thirteen of us who took the July examination, the other

twelve being medics. I asked the Secretary of the Board if I held up the end for my school, and he said, 'You certainly did; you passed a fine examination, and you got a very high mark.'

The examiner in obstetrics and gynecology, (which by the way were the hardest subjects), congratulated me and said if I was as good in practice as I was in theory, I was a "wonder."

All of the doctors of every school have treated me nicely, and all of the D. O's. have been cordial.

I am the second D. O. to take the Utah board examination, the first being Dr. Alice Houghton, an Axis girl, now practicing in Salt Lake City. She gave me all the pointers she could and I will help the next D. O. if he will ask me.

One more thing before closing. The three years I was in the Club we never had an entertainment for the benefit of the Club, but assisted in benefits for the Athletic Association and other societies, etc. Now this year you fellows get up a circus, minstrels, or something, and put the proceeds in the Clubhouse Fund. If you do not see the point, start Lacy's wheels going."

\* \* \*

**Price.** What becomes of editors of THE BULLETIN? This is a serious question in some of its phases. We have asked several former editors to give us a lift on THE BULLETIN, believing that they, appreciating the position in which the editor of THE BULLETIN invariably finds himself placed, would respond, but they haven't!

We did not ask brother Price to lift, because he had THE BULLETIN to uphold all last year, and needs the rest. But just the same he blossoms out from Alexandria, La., where he located last month and gives us a message.

Doctor Price is a strong believer in the practical feature of the Club. With him, we believe, it is the carrying this work to the highest degrees that has built up and placed the Club where it stands to-day.

The doctor urges us to use great care in the selection of members. While it is true that the various organizations and fraternities of the school entertained the freshmen prior to the Atlas Club, we believe it will be to our good. If they are suited with the other organizations they would not be with ours, and so we have lost nothing.

Dr. Price closes with "Here's wishing THE BULLETIN, The Atlas Club, and the A. S. O. continued success."

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**Pellette.** We have a pleasant letter this month from Doctor Eugene F. Pellette, of the last graduating class, who is located

in Southwest Kansas. Dr. Pellette says he is the only osteopath in an area of 6000 square miles, which we must admit is "some field." The trouble is not the doctor's capacity for work, but the "field" is sparsely populated, so that outside of the practice he is establishing at Liberal, (his postoffice address) and adjacent country, he is not burdened because of the large territory he has to draw on.

On another page will be found two or three very interesting case reports which Dr. Pellette was good enough to forward. Having been assistant to a former editor of THE BULLETIN, Dr. Pellette appreciates the fact that "copy" is rather scarce during school year.

\* \* \*

**Willard.** We haven't had anything from Dr. Asa Willard, of Missoula, Montana, of late, but he is still osteopathic and expounding as well as practicing.

The "Daily Missoulian" in its issue of Sept. 15th devotes several columns to the reproduction of Dr. Willard's paper read at the Montana State Osteopathic Association, held at Bozeman, Mont., Sept. 14, 1909.

The article deals with the early history and theory of osteopathy, and will advance the cause among its readers.

\* \* \*

**Prindle.** Prindle's in Washington—not where they grow the big apples, but where they monkey with the tariff and kindred things.

He took charge of the practice of Dr. Talmadge during the summer months, while the latter was on his vacation, but October first opened offices in the Colorado Building.

Dr. Prindle reports very satisfactory results and is more than ever convinced of the possibilities of osteopathy.

E. E. E.

\* \* \*

**Groenewoud.** We acknowledge with pleasure a card announcing that John C. Groenewoud, graduate of the American School of Osteopathy has opened offices for the practice of his profession in the Foster Bldg., Cor. 47th St. and Kenwood Ave., Chicago.

The card don't say so, but we know "Uncle John" keeps open house for Atlas men. Here's success to him.

\* \* \*

**Hollis.** Never heard of him? You will. Hollis is from London, he's a "Baby Freshman" and an Atlas man; he's a B. A., and a violinist of ability; but what warms our heart toward him is that he is imbued with osteopathy.

While young to pose as an authority on osteopathy, he contributed an able abstract article on the science which appears in the October "Osteopathic Journal." Read it.

**Robinson.**

A letter from Dr. John W. Robinson, ('06) of Erie, Pa., says that receiving THE BULLETIN is like getting a letter

from home.

"One of the best moves I ever made in my life was when I joined the Atlas Club" writes Dr. Robinson. "It did me lots of good and I hope it will do as much or more for every man who joins its ranks.

\* \* \*

### THE KNOCKER.

There is not a bore so tiresome  
As the pessimistic crank,  
Who is sure there's nothing wholesome,  
But that everything is rank;  
Who sees no good in any,  
Who at hopefulness doth mock,  
And whose mission, self appointed,  
Is to knock—knock—knock.

He's the millstone of all progress,  
He is wholesome effort's bane;  
He can just see the evil,  
Naught to him is safe or sane;  
He is there to put a damper  
On all projects to unlock  
New doors to progress, coming  
Just to knock—knock—knock.

He paralyzes effort,  
He invites distrust and fear,  
He pulls down and dismantles,  
Where another man would rear.  
Would that in the chair electric  
We could stop with fatal shock  
The man whose object  
Is to knock—knock—knock.

—By Josh Wink in the Baltimore American.



The inquiry in regard to the Axis yell in the September number of THE BULLETIN brought forth a short but interesting letter from Dr. Lola L. Hays dated Sept. 23, '09, in which she says the yell was written by Dr. Emmeline Tappan Culley and herself in 1900. There is no particular history connected with it. It was just the outcome of a desire for an Axis Club yell and Drs. Hayes and Tappan set to work to manufacture one. The yell printed in last month's number was the happy result of their combined efforts. We would suggest that some action be taken by the Club and it be made our permanent property as the Axis Club yell. It is worthy of the place.

\*\*\*

A communication postmarked Heidelberg, dated June, 1909, was received from Doctor and Mrs. Gerline thanking the Axis Club for their much appreciated card of good wishes.

\*\*\*

Dr. Catharine DeVeny informs us of her change of address. It is at present 6218 Lexington Ave., Chicago, Ill.

\*\*\*

Dr. Elizabeth M. Ingraham's correct address is 506 N. Vandeventer Ave., St. Louis, Mo. In her communication to the Secretary she extends her best wishes to the Club and says that she is pleased to hear such good reports from it.

\*\*\*

Miss May Potterf one of the Axis '10 girls, whose illness was noted in the September Bulletin, acknowledged the receipt of a postal card shower at Silver City, N. M., given her by her classmates.

\*\*\*

Dr. Lola L. Hayes, Moline, Ill., advises the Axis Girls of a prospective trip abroad, starting next February, from San Francisco and eventually landing in New York, five months later. This includes a side trip across Europe and seeing the Passion Play at Oberammergau. The Doctor extends best wishes to the Atlas as well as the Axis friends.

We hope that her friends will hear more of this trip later.

Dr. Belle Givens received a very interesting letter from Dr. Frances Hamlet Thoms, Axis, '09, in which she says that she is located at 1511 East Mercer St., Seattle, Wash.

\*\*\*

THE BULLETIN mailing list has been revised and those who were more than two years behind in dues were dropped from the list. Anyone failing to receive THE BULLETIN after this month and knowing herself to be in arrears in dues will be restored by sending the same. Anyone who does not know her standing can find out by writing to the Financial Secretary.

\*\*\*

Dr. Emma Crossland, Axis, '06, who has been seriously ill with typhoid fever in the Hospital, we are pleased to announce is recovering.





# AXIS GRAND CHAPTER.

President, Dr. Bertha Buddecke, Suite 816 Carleton Bldg., St. Louis, Mo.  
 First Vice-President, Dr. May Vanderburg, 2069 Sutter St., San Francisco, Calif.  
 Second Vice-President, Dr. Margaret B. Carleton, Post Office Bldg., Koene, N. H.  
 Secretary-Treasurer-Editor, Dr. Nannie J. Chappell, Suite 510 Mo. Trust Bldg., St. Louis, Mo.

Chaplain, Dr. Elizabeth M. Culbertson, Appleton, Wisconsin.

Janus, Dr. Julia M. Sarratt, Waco, Texas.

Escort, Dr. Almeda J. Goodspeed, 126 State St., Chicago, Ill.

Trustees: Dr. Sarah Russell, Five years, Term expires 1914; Dr. Ethel L. Burner, Four years, Term expires 1913; Dr. Almeda J. Goodspeed, Three years, Term expires 1912; Dr. Nellie F. Whitecomb, Two years, Term expires 1911; Dr. Minnie Schaub, One year, Term expires 1910.

The officers and trustees constitute the Executive Committee.

INVESTIGATING COMMITTEE:—Dr. Nettie H. Bolles, 1457 Ogden St., Denver, Colo.; Dr. Jessie L. Catlow, 623 Story St., Boone, Ia.; Dr. Effie Rogers, 12 Hemenway St., Boston, Mass.

PROGRAM AND COURTESY:—Dr. Ella D. Still, 1716 9th St., Des Moines, Ia.; Dr. Susan Balfe, 505 Mason Bldg., Los Angeles Calif.; Dr. Eita C. Wakefield, 714 Union Savings Bk. Bldg., Oakland, Calif.

FINANCE AND AUDITING:—Dr. Chloë Riley, 43 W. 32d St., New York, N. Y.; Dr. May Marts, 147 Forsythe Bldg., Fresno, Calif.; Dr. Fannie B. Laybourne, 210-11 First Ave., Denver, Colo.

CONSTITUTION AND BY-LAWS:—Dr. Pauline R. Mantle, 404 Pierik Bldg., Springfield, Ill.; Dr. Carrie P. Parenteau, 6540 Yale Ave., Chicago, Ill.; Dr. Ethel L. Hearst, 122 N. Santa Fe Ave., Salina, Kans.

The Chairman of each committee being the first named.

We urgently request all members who know themselves to be delinquent with their field dues, to send them in to the Financial Secretary of the Odontoid Chapter. If you are in doubt write and find out how you stand. Do not, we beg, neglect this duty another day as to be a Grand Chapter member in good standing, all dues should be paid.

\* \* \*

But two members have responded to our appeal in the September Bulletin for the payment of the 25 cent Grand Chapter dues. We are grateful for the prompt response of these two but dear sister members, our gratefulness would be exceedingly great if a few dozen more of you would do likewise.

\* \* \*

### LETTER TO THE GRAND CHAPTER, AXIS CLUB.

(This is not intended as a scientific article in any sense but simply an account of a few items of interest to me, and possibly to others.)

My people, for some years have wanted me to visit Florida in the

summer time, saying the summers there were far cooler, than in my section, of the Middle West. But I demurred, expecting to suffer with heat and insects. This year, however, I went, and remained nine weeks, finding the summer climate a very comfortable one, and much better than in St. Louis.

My brother has lived in St. Augustine for many years, and has a summer bungalow on Anastasia Island on the Atlantic Coast, three miles east of the mainland.

This island is eighteen miles long by one and a half to two wide, and has in years gone by, been the scene of conflict between the Spanish, French and Indians. Old Fort Matanzas at its southernmost end, is still standing as a ruined monument to the energy of the Spanish. It is the oldest fort in existence in the United States. While the greater part of the country was suffering from the torrid weather, we had only four days of over ninety degrees in the shade weather on the island, and no hot nights.

We had fine bathing, the water being nearly always deliciously soft and velvety, fine breezes day and night, with lovely blue sky over us, and some of the most gorgeously beautiful sunsets to be found anywhere. We had the whole sweep of the horizon in its sunset or sunrise glory.

At times the ocean in front of us (usually during the middle of the day) showed wonderful opalescent tints, when here and there through the dark blue of the water exquisite strips of Nile green, or soft pink would appear—such colors as the Bahamas are noted for.

As to insects, except for two weeks every summer, when little black mosquitoes are in force, and then suddenly disappear, we had no more flies nor mosquitoes than are in Ohio, Illinois, Michigan or Missouri, and with well screened houses, few are in evidence.

I caught and examined some of the mosquitoes. Those found were the culex or rain water mosquitoes, either all black, or black with nicely striped legs, and innocent of conveying disease so far as known. There are many varieties in Florida, and some sections have the anopheles or malarial variety, but not where I was. So far as heat and insects are concerned, I may try Florida again as a Summer Resort.

The visitor to Florida in the winter does not see the tropical fruits, which are at their best in summer.

In July and August the pine-apples are perfection, and the bananas, which ripen on the plant, are a joy and not the bane to digestion of the green picked fruit. A banana when ripe is mealy and of delicious flavor, and one crisp to the teeth in biting is not fit for the human stomach.

The Avocado pear in looks and color resemble a large green or purple

egg plant and contains a seed as large as an average potato. Its flavor is queer and indescribable, but people grow to love it. It looks like a cantaloupe, with the seed removed, and is eaten with pepper, salt and lemon juice, or Worcestershire Sauce.

The mangoe is of a pinkish yellow, usually the size of a large, smooth tomato. It contains a large oval seed  $1\frac{1}{2}$  inches wide by 3 inches long. It has a firm juicy pulp, with a flavor of turpentine dashed with cinnamon.

Most accomplished is the person who can eat a mangoe with elegance. The fresh figs of different kinds, and the guavas of beautiful pink or salmon complexion were fine. The latter despite their lovely looks have a most unpleasant smell, which many people dislike exceedingly. Mangoes and guavas are certainly on acquired taste.

The Southern papers had a good deal in them about a disease, not known in the North—the Hook Worm disease—and Pellagra, the old world disease, which has lately appeared in this country.

For a fine description of the Hook Worm disease, the parasite of which was discovered and segregated by, Dr. C. W. Stiles, read articles on it by Frances Maule Bjorkman in *World's Work* for May, and Mary Hamilton Carter in *October McClures*. It is thought that many times the Hook Worm enters the system by way of excoriations on the feet from the Ground-Itch, as many who have Ground-Itch develop Hook Worm.

Ground-Itch is peculiar to the South, and attacks the feet and legs only, as a rule, and is acquired by children, and others who go barefooted.

Two probable cases of Hook Worm I saw, presented the ashy face, anaemia, the lassitude and sleepiness, and distended abdomen, described by Dr. Stiles.

#### HOOK WORM.

Hook Worm, or *Necator Americanus*, as described by Dr. C. W. Stiles has the following symptoms:

"Skin yellow and waxy; eyes without color or sparkle; expression dull and intensely melancholy; extreme emaciation and peculiar dropsical condition of face, abdomen and extremities. Sometimes they are called shad-bellies.

"The parasite itself is one-half inch long, and as big around as an ordinary hair-pin.

"The parasites wound the intestinal wall, not once, but many times, and attach to the mucous membrane, and suck the blood, at the same time poisoning him with their waste products. They produce hemorrhages as they move from point to point, and the victim loses blood in addition to what is taken by the parasite. Profound anaemia, and heart, stomach and bowel disturbances accompany it."

It has been called the lazy sickness, and has been treated as malaria, or pernicious anaemia. Sheep and dogs also have it, and convey it to people

Dr. C. W. Stiles of the U. S. Marine Hospital has been the discoverer of this important disease. While much ridiculed at first, he has well "proven his case."

Medically it is treated with thymol and epsom salts, and unless in the last stages, Dr. Stiles says it can be cured.

Osteopathy should do finely in treating it.

#### PELLAGRA.

Osler says: "Pellagra is a nutritional disease, supposed to be due to the use of fermented, sooty, or musty maize.

In the early stages it is characterized by debility, pains in the spine, insomnia, digestive disturbance, more rarely diarrhoea.

The first clear manifestation is the pellagral erythema, which usually appears in the Spring.

This is followed by desiccation and exfoliation of the epidermis, which becomes rough and dry, and crusts occasionally form, beneath which is suppuration. Salivation, dyspepsia, and diarrhoea occur.

In severe and chronic cases, are headaches, backaches, spasms, paralysis, and mental disturbances, melancholia and suicidal mania occur at the third or fourth attack and a pronounced cachexia."

The *Post-Dispatch* of September 11th reports a case at the City Hospital in St. Louis. Cases of Pellagra were reported from North and South Carolina, Georgia, and Alabama, and a few from Illinois.

This uncommon disease is being investigated to see whether it is a germ disease, or from eating poor, musty, fermented or sooty corn or wheat as has been supposed. It prevails in the poorer classes of the country districts of Spain, Italy, the South of France, and some parts of Russia.

In the Georgia State Insane Asylum thirty-eight cases of Pellagra had been reported to September 1st. As poor food was not the cause of it in this institution, the authorities were much puzzled as to how this disease could have gained entrance there.

Osler was the first one to include it in his list of diseases in this country, and gives a complete description of it, in his *Practice of Medicine*.

As it has been supposed to be a nutritional disease it will be of interest to note the results of the experiments by Bacteriologists in regard to proving it of microbic origin.

DR. ELIZABETH M. INGRAHAM.

## A RESPONSE.

BY DR. PAULINE R. MANTLE.

Believing that "Free and fair discussion will ever be found the firmest friend of truth," I bring, by request, a response to the message delivered by our esteemed outgoing President, Dr. Jenette Bolles, in her address before the annual meeting of the Axis Club at Minneapolis, which appeared in the September Bulletin.

In it she voiced the message given out by Mrs. Charlotte Perkins Gilman of the unrest of women in the homes whose inclinations lead them to long for the development of their abilities in professional and business careers. I bring my message from women in happy homes who make of their homes a business career of the greatest magnitude where freedom is not limited but enlarged.

These women regard home-making and home-keeping as the greatest interest belonging to all the interests, of the world, and the rearing of their children as the business of greatest importance to the world. Such women look upon their homes as the holy of holies wherein is born the highest ideals of life.

There is no clearer solution to the total problem of life than that of interesting all women and all men in the kingdom of the home. There is a need for the boys and girls to be taught to believe in the dignity of things pertaining to the making and keeping of their homes.

There is a need that women and men should conduct the homes methodically as any other business is conducted; that the duties should be distributed systematically among its members, giving each one some worthy incentive for doing the work well.

There is no reason why a child should not be taught, as early as possible to take its place in the making and keeping of the home, thus growing into taking on responsibilities that fit him for the greater responsibilities of his life work without being conscious that such preparation is going on.

Circumstances have given woman an opportunity to develop an understanding of herself. When truthful with herself she desires to be only a woman, yet a woman to the length and breadth of all possibilities, to live out her nature in action and taking an active part in the world of action.

There is no reason why every woman should be a housekeeper any more than that every man should be a farmer, but there is reason why every man and every woman should admit that home-making housekeepers and intelligent farmers are the peers of those in any other occupation.

They are the people who are free and independent enough to take a vacation, at will, without fear of losing their position or practice.

There is no reason why every woman should love house work, but there is no reason why she should despise it.

Nothing is easy that we do not know how to do well. Woman has proven herself capable of doing many things, but no woman should feel that anything is a better occupation than is found in the home.

Since home is the recognized foundation of our national life, how can there be a better calling than that of home-making or, I may add, a more difficult? We need skilled and expert home-makers just as much as we need experts in other lines.

There is no earnest, thoughtful, conscientious woman who does not in her heart cry out, "O, where can I learn what I ought to do?" This is no new experience, but we are only lately coming to the realization that much of the unrest comes from the lack of training in the tasks she is most likely to assume.

The sentiment should grow in favor of furnishing every boy as well as girl a systematic drill in the art of home-making.

When boys are so trained, men will appreciate what it means to keep a home and woman's work in the home will rise to the dignity of being regarded as equally balancing that of man in the partnership of life.

There is urgent need of the skilled services of women as doctors, sanitary inspectors, members of school boards, school inspectors, superintendents of hospitals, asylums and places where women and the young of both sexes are employed.

In all such places there are many things that would be more readily brought to the notice of women than men holding similar positions.

Women and electricity are classified as the two forces making the greatest progress of the age. Women are entering into a broader sea of life and responsibility.

The coming years of the twentieth century will see women political economists and social economists, but then as now the highest responsibility, the noblest function of woman, the most potent feeling that dominates her being will be that of motherhood.

In the moral sense all women are mothers. Happy they who are mothers in both the moral and physical sense.

"Knowledge is power" and power means duty. No class of women have better knowledge of homes and lives of individuals than those of us who are doctors.

The duties of the doctor are not done until all instructions within

his or her knowledge are given that will morally, physically and mentally help the condition of the patient. The implicit faith in what a doctor says is well illustrated in the case of Pat who was injured in the building of a sky scraper and was taken home in a seemingly unconscious state. A doctor was called and examined him and said to the wife, "He is dead." "You're a liar" exclaimed Pat. His wife said, "Hush Pat, the doctor knows best."

We who live in the present are the heirs of all the ages. We may safely and with justice claim a knowledge, a power, a poise that has come through strenuous labor and thought of those who have gone before us.

The women of the osteopathic profession should shine as mighty levers in effecting the regeneration of many lives that come under our treatment and influence.

As strength comes from unity and organization the Axis women may study many ways in which to serve our country and honor the founder of our science, who honored woman by recognizing her worth in osteopathy.

By thinking and working along socio-economic lines while we study, and work and think along osteopathic lines we may broaden our views of life, broaden our mental horizon and our ability to help others. May we not only "live and let live" but "Live and help live."

\* \* \*

#### DO NOT FORGET

To read THE BULLETIN.

Your Grand Chapter dues of 25 cents a year.

To send the Financial Secretary of the Odontoid Chapter \$2.00 each year for five years.

That a Grand Chapter membership is a great honor and a very great privilege.

The Grand Chapter has a membership of several hundred.

THE BULLETIN is your magazine and a good one.

It aims to keep in close communion with sister members, to give you good scientific articles from many of their pens, to chronicle their doings, sayings, whereabouts, etc

That it takes work to get it out each month.

THE BULLETIN is strong but it should be larger, better, stronger

That to make it larger, better and stronger means more work for your Editor.

One can not do it all and do it well.

That a contribution of a bit of news, or a good case report from a

few sisters each month, an article on almost any subject, now and then, from a few others, would be joyously welcomed.

That if each of you will do your part and do it now, the Bulletin will be very much better and the Grand Chapter department great.

That this means you. You can not all be sent a personal invitation to "give to your own." It would take time and your editor hasn't it to spare, she is busy even as you. It takes stationery and stamps and your treasury is not overflowing, it is not even full, in fact it is about empty.

To tear this reminder out and paste it on your mirror or desk lest you forget.

\* \* \*

#### AXIS FIELD NOTES.

Dr. Elizabeth Shupert of Rockford, Ill., sends in her Grand Chapter dues with best wishes for all.

\* \* \*

Dr. Ida Ellis Bush of Jacksonville, Fla., has moved into a handsome suite of rooms in the new Atlantic National Bank building.

\* \* \*

"Accept my congratulations on your first issue of our Grand Chapter department. The September Bulletin is good." Dr. Mary Lyle Sims, Columbia, S. C.

Glad you like the Department doctor and certainly appreciate your taking the time to say so, and doctor, should you at any time, have an item of news, or in fact anything that you think might be of interest to our sister members, why kindly pass it along.

\* \* \*

Have you paid your Grand Chapter dues of 25 cents a year? We have a number of receipt postals for 1909 that we will be delighted to distribute among the members before the year closes.

\* \* \*

Twenty-three new members enter the field from the June, '09 class and the Grand Chapter extends a hearty greeting.

They are, Drs. Almedia F. Thompson, Fanny Thoms, Rose Wisner, Evelyn Young, Mary Ray, Mary Ewing, Carrie Mundie, Charlotte Sawyer, Grace Shupe, Nellie Marey, Caroline Stealy Mayes, Mary Witten Peery, Mary E. Perrett, Estelle Poulter, Edna Asheroft, Florence Boles, Mand Barger, Eva Barger, Nellie M. Ferry, Crescence Henke, Clara E. Henke, Nora B. Pherigo and Belle Givens.

The Secretary-Treasurer requests each new member to send as early

as possible, her correct address that it may be published in THE BULLETIN.

\* \* \*

Dr. Mary L. Sims of Columbia, South Carolina, is in her office again after a very enjoyable seven weeks vacation. Dr. Sims visited Yellowstone Park and at least twenty other points of interest in the west. She also called on several Axis sisters and reports them all busy and prosperous.

\* \* \*

We were very glad to receive a letter from Dr. Florence A. Covey of Portland, Maine, stating emphatically that her practice is not for sale never has been and that she is perfectly contented in Portland and in her practice. Dr. Covey allowed her name to be used in a friends ad. and thus the Bulletin fell in error.

## LOCATIONS AND REMOVALS




- Bakhouse, Dr. Clara, from Osage City, Kans., to Kirksville, Mo.  
 Bean, Dr. A. S., from 392 Clinton Ave., Brooklyn, N. Y., to 34 Jefferson Ave., Brooklyn, N. Y.  
 Bowen, Dr. Margaret, from 102 E. Grace St., Richmond, Va., to the Virginia Bldg., Richmond, Va.  
 Bush, Dr. Ida Ellis, from 32 W. Monroe St., Jacksonville, Fla., to Suite 707-9 Atlantic Nat. Bank Bldg., Jacksonville, Fla.  
 Coke, Dr. R. H., from Kerrville, Texas, to 411 W. Chestnut St., Louisville, Ky.  
 Groenewoud, J. C., has located at 1339 E. 47th St., Chicago, Ill.  
 Ingraham, Dr. Elizabeth M., from 303 Century Bldg., to 506 N. Vandeventer Ave., St. Louis, Mo.  
 Knapp, Dr. Lester I., from Hotel Regent, New York City, to Sherman Square Hotel, Broadway & 70th St., New York City.  
 Laybourne, Dr. Fannie, from 210-11 First Ave. Hotel, Denver, Colo., to 634 Pearl St., Denver, Colo.  
 McKinney, Dr. C. De Gress from Lebanon, Mo., to 19 Norfolk Bldg., Cincinnati, Ohio.  
 Murphy, Dr. E. C., from Danville, Ill., to Eau Claire, Wis.  
 Dr. Carrie Mundie, at Kirksville, Mo.  
 Perrett, Dr. Mary E., from Kirksville, Mo., to Tacoma, Wash.  
 Pherigo, Dr. Nora B., from Kirksville, Mo., to Fulton, Ky.  
 Price, Dr. H. A., from Houston, Texas, to 430 DeSoto St., Alexandria, La.  
 Prindle, Dr. R. H., from Kirksville, Mo., to 415 Colorado Bldg., Washington, D. C.  
 Ray, Dr. Mary I., from Kirksville, Mo., to 106 Chestnut St., Roselle Park, New Jersey.  
 Spencer, Dr. Bessie, from 325 Main St., Ridgway, Pa., to Kirksville, Mo.  
 Thomas, Dr. Frances H. has located at 1511 E. Mercer St., Seattle, Wash.

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## ATTENTION !

The Business Manager of the Bulletin has made certain statements regarding the number of people who read Bulletin advertising. The following experiment will be an indication as to whether or not his statements are correct.

In certain advertisements in this issue of the Bulletin there is a misspelled word. The first person—man, woman or child—reporting to the Business Manager either of the misspelled words and the name of the advertiser in whose advertisement the word was found will be given a written order upon that advertiser. Upon presenting this written order to the advertise, you will be given a nice prize. No person will be allowed to present two or more words unless the first or the first and second words presented have already been presented by some other person.

Remember there is more than one chance so be sure to report your findings to

'Phone 741

M. A. BOYES,

Business Manager of THE BULLETIN.

## A WORD TO OUR ADVERTISERS.

There will be one more issue of THE BULLETIN before the Thanksgiving holidays. You will probably wish to change your ad and tell us the good things you will have in stock at that time. For this reason the Business Manager of THE BULLETIN will call for your ad Friday afternoon, November 5. If convenient for you to have it ready at that time I feel sure it will prove mutually advantageous.