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Our Present Concepts of Health and of Disease — Are They Adequate?†

ANTON J. CARLSON*

It is a privilege, as well as a responsibility, to be with you tonight. I am considerably older than you may think. I remember the day of small things in the case of Washington University Medical School. You have been part of the extraordinary development in medical education and medical research in the United States in the last fifty years. The next fifty years in United States medicine can be equally interesting, equally challenging, and equally startling. It certainly has been a privilege to live through this half century of medical progress when America really has come into its own, not as an absorbing sponge of wisdom gathered in other lands, but as actually producing new information in our own home.

It may be a little discouraging when I tell you that what we know today in medicine is a mere fragment to what remains to be found out. You will learn gradually that all the minutiae that seem to cover every medical problem and field, and stuff to suffocation the cerebrum in the front of the parietal lobes, don't need to be all the time on the retina, in the cortex, or in consciousness. When you have mastered the fundamentals you can put much of the minutiae down into the hypothalamus. Experience will call these thousand spirits from this wasty deep, when you need them, if you once mastered them and never forget the fundamentals. I say that, without being a pupil of Freud.

† Presented at the opening of the School of Medicine for the year 1941-42, September 24, 1941.
* Professor of Physiology, University of Chicago.
Two days ago I listened to a very wise talk by a very wise physician to another group of medical freshmen in another part of the country. Among other things, he said that the medical student should learn early to develop hobbies. If you come—and woe to the man or woman who comes in any other way—if you come thoroughly *conditioned to the philosophy of labor*, then I think there is just one hobby that is paramount to you and to me, and that is the nursing of the habit of using our head at all times. I never did understand how anybody could identify heaven with leisure, with no difficult work, with the end of the opportunity of learning *new things*. In that respect it is my considerate judgment that you freshmen, if you endure, if you survive—are entering the most interesting, the most challenging, and the hardest of the professions in our times. There is certainly for us, in biology and medicine, like for the Athenians in the days of Paul, something new to be sought and valued every day.

Dean Shaffer forced a subject on me for this talk: “Our Present Concepts of Health and of Disease—Are They Adequate?” Maybe I can focus the point of my discussion a little by referring in brief to two recent events in medicine and nutrition. We have heard in the last eight years from many sources that a third of our population, or roughly forty million citizens, are underfed—in addition to being poorly clothed and poorly housed. Now, that has been added to recently, so that today, not forty million but 95 million Americans either cannot get the right food or have such bad eating habits that they don’t eat enough of the right food. If this is so, we have before us a tremendous problem of malnutrition. I quote here from the statement of Dr. Thomas Parran, Chief of the United States Public Health Service, made at the Nutrition Congress for Defense, in Washington last Spring: “Studies of family diets by the Department of Agriculture in all income groups of the Nation show that one-third of our people are getting food inadequate to maintain good health—and less than one-fourth of us are getting a good diet.” What are the facts? I have been accused of always asking for the evidence, and I am asking for the evidence of my distinguished friend, Dr. Thomas Parran. At the same Congress, the honorable Paul V. McNutt, administrator of many of our Federal Welfare
Bureaus, including the Public Health Service, added much more. Mr. McNutt said: “Stamina, intelligence, judgment, will, stability may have their roots in vitamin unbalanced diets, and can be treated through clinically determinable doses of synthetic vitamins.”

I think Mr. McNutt meant “vitamin balanced diets,” but the statement that disorder in these fields “can be treated through clinically determinable doses of synthetic vitamins” seems clear enough. It pains me to say that this is a mouthful of administrative medicine and political science from a public official trained in the law. And then he supports this with the usual lay testimonials of quackdom. I quote again from Mr. McNutt’s speech: “Recently I was told that a Western Trucking Company had actually achieved a reduction of its night accident rate by providing all its drivers with bags of raw carrots at the beginning of each trip.” These are tragic things, because it is said by Government leaders in our field. To me it looks like a sin against science. It may frighten our fellow citizens. It certainly will encourage quackery, and put many dollars into the pocket of the vendors of synthetic vitamin pills. That synthetic or natural vitamins will empty our insane asylums and our prisons,—for who will argue that crime is an act of intelligence,—that I shall accept when I see it. There is probably a little rabbit down that hole, but in the name of sanity and science, let us do more digging and less talking, till we actually have that rabbit in our hand.

We are not told what the truck drivers did with these bags of carrots. Did they hang them around their necks, or did they chew and swallow them? Or was this little item not checked? If they chewed the carrots, somebody who knows should have told Mr. McNutt and the officers of the Trucking Company that chewing carrots or chewing the rag are aids to keeping awake, no matter what it may do for the rhodopsin of the retina.

It is regrettable that a physician, with the standing and responsibilities of Dr. Thomas Parran should take the absence of knowledge as the basis for the statement, that less than twenty-five percent of the population of these United States eat adequately or eat right, when we do not even know what is the optimum diet for man through the changing periods of
his life. Dr. Hazel K. Stiebling, of the U. S. Department of Agriculture, who has had a large responsibility in the conduction and interpretation of our Federal nutrition surveys, points out in the last year’s Annual Review of Physiology, that one of the crying needs of today is the development of methods through which we may detect the possible if not probable injuries from faulty diets before the well-known and now recognizable deficiency diseases are on us. If, as it seems to me, Dr. Parran and Mr. McNutt left the reservation of scientific medicine in one direction, my good friend, Dr. Logan Clendening of this State, leaves our reservation at the opposite point of the compass. In the last number of the Journal of the American Medical Association, Dr. Clendening presents in a brief paper (which I hope all of you will read, if you have not done so) quite a bit of statistics from many clinics and from able physicians all over these United States, to the effect that the number of actual cases of vitamin deficiencies are astonishingly small in our land, and he gives the inference from this small number, that we have no serious vitamin deficiency problem before us. In my judgment, both Dr. Thomas Parran and Dr. Logan Clendening sin against the scientific method. We should stick to facts. We should be as modest as the good clinician who in doing a physical examination goes over every organ system with the best tests now available. He goes over the heart, the chest, the gut, the kidney, and what does he put down on the record? Heart—does he write healthy? No. Heart, negative; kidney, negative; gut, negative. That means he has not found recognizable disease. He does not give a positive affidavit that everything is alright. In most of these examinations we do not put the individual organ, or the patient as a whole, on stress; and we have no measure of how far his factors of safety or his powers of regeneration have been impaired.

I should say that our present conception of disease is fairly adequate. But it is still provisional. It is far more adequate than our conception of health, because our conception of health is essentially the absence of clinically recognizable disease. And we now know that starting out with the reserves, with large factors of safety, and with great capacity for regenera-
tion in many tissues, we may sustain a great deal of damage before recognizable disease appears.

We have now solved the riddle of many of the diseases that baffled us fifty years ago. We haven't controlled all of them, but we understand them, in part. Among these are pernicious anemia, diabetes, endocrine disorders, and the dietary deficiency diseases. Now that that is partly done, there remain the virus diseases, there remains cancer—yes, there remain many troubles. But, it seems to me that the next big step to tackle is that involving better methods for determining initial damage to, and the degree of loss of, our reserves, because that alone, will make periodic physical examination of the so-called healthy people mean something. That alone will give us an approximate definition of health. This is nothing new, nothing startling. In "Science" a few months back Dr. W. B. Cannon, of Harvard University, who is one of the many ornaments of the last fifty years of American Medicine, presents a paper entitled "Problems Confronting Medical Investigators." He outlines what we need, only in different words and with different emphasis. I would not call them problems confronting medical investigators; I would call them problems confronting medicine, problems confronting us all, problems confronting society. I believe, to be sure, that the medical investigators form the spearhead of the advance. And it is going to be somewhat more difficult and costly to do the work of the next fifty years, than some of the things accomplished by the past generation.

In retrospect, some of the things look simpler than what is facing us now, particularly the teaching of medicine. To me teaching is a great privilege, but it would not be so challenging, except for the fact that some time, somewhere, in St. Louis, in Boston, Chicago, San Francisco, or Baltimore, there is going to sit on the freshman bench a man or a woman who will do greater things than Pasteur, and Koch, and Harvey, and Minot. But all the work in conquering these new frontiers cannot and will not be done by those few.

I think that our next generation of physicians will probably do better than did we, provided we retain our sanity, our courage, and our freedom. For science is the creation of free men, with superior intelligence, great industry, patience and cour-
age, through the ages. In our early training let us really get conditioned to the scientific method. Let us never forget that, except for a few superficialities, every patient meeting us is a scientific problem *challenging analysis*. If, in addition, we keep both feet on the ground all the time, we will never commit any great sin against science, or any grave crimes against the tradition of our craft.

What I have said so far may stir some of my colleagues in the science and art of medicine to say: “Carlson himself has gone off the reservation.” I know perfectly well that the term “subclinical disease,” an assumed ailment that no present objective criteria can detect, but perceived by the seventh sense of the soothsayer, is also the concept and the method, the universal method, of the medical quack. But while the term “subclinical disease” is a misnomer, we in the science and art of healing must begin our work much earlier. We must not wait for the time when the reserves are so depleted and the individual is so sick that he comes to us. We must redefine our concept of health. When that is done on a factual basis, the concept of disease will take care of itself.

JOHN F. PATTON, M.D., ’28

The first ureterectomy was performed by Reynier in 1892 for an infected ureteral stump responsible for severe symp-toms after nephrectomy for pyonephrosis. The first planned nephroureterectomy was carried out by Kelly in 1893. He reported three cases, all renal and ureteral tuberculosis, the ureter being removed to the level of the broad ligament or to its point of entrance to the bladder. Albarran in 1898 performed the first nephroureterectomy for papillomatosis of the kidney and ureter. Various articles have appeared in the literature since that time including Beer’s proposed operation of aseptic nephroureterectomy and that of Gutierrez who advocates exposing the ureter first and cutting it away from the bladder before proceeding with the removal of the kidney. The present discussion is limited to the method of treating the lowermost portion of the ureter, namely the intramural section, whether ureterectomy is carried out as a primary nephroureterectomy or as a secondary procedure necessitated by future developments. The term ureterectomy is often misapplied. In the true sense of the word it means removal of the ureter in its entire length which would include that portion which passes through the bladder wall to and including the ureteral meatus. According to Papin, radical or total ureterectomy must include this intramural section, juxta-vesical ureterectomy indicates removal flush with the bladder, and removal at any higher level should be labeled subtotal or partial ureterectomy.

The intramural ureter is of special significance in papillary growths of the renal pelvis and ureter because of the peculiar characteristic of transplantation inherent in this pathological condition, and which makes it imperative that the entire

* Condensed from paper read at the annual meeting of the South Central Branch of the American Urological Association, Galveston, Texas, Sept. 27, 1941.
ureteral mucosa be excised or destroyed. Tumor implantation occurs more frequently in the lower ureter and has been shown to occur in the intramural section. Most surgeons in performing ureterectomy speak of removing a cuff or button of bladder wall surrounding the intramural ureter; putting tension on the ureter and clamping across a portion of the bladder with the hope of including the intramural section, has been proposed. Colston in 1933 reported his technique of cutting the ureter just above its entrance to the bladder and destroying the mucous membrane of the remaining segment by fulguration. These procedures, performed for the most part blindly seem to fall short of the desired result. Any remnant of mucous membrane left behind may be the nidus for recurrence of the neoplasm and it would seem preferable to employ a procedure by which the intramural ureter and ureteral orifice are accurately excised under vision.

The following technique of extravesical removal of the intramural ureter is proposed and has been employed successfully in two cases.

**Operative Technique**

Immediately preceding operation, a cystoscopy is done and a #5 ureteral catheter passed up the affected ureter and left in place, the bladder being completely emptied. Though not essential, the presence of the catheter acts as an aid in locating the ureter and also later in more easily identifying the ureteral orifice. An incision is made parallel to Poupart’s ligament, the muscles divided and the peritoneum retracted medially. The ureter is identified, picked up, and completely separated from all structures down to its entrance to the bladder. Tension is put on the ureter, and the bladder wall above and to each side is grasped with Allis forceps. With the ureter still under tension and using the curved Mayo dissecting scissors, the wall of the bladder is separated from the intramural ureter by blunt dissection, freeing the anterior half first. This is accomplished by placing the belly of the scissors on the anterior wall of the ureter with the tip at the bladder juncture and spreading the muscle fibers of the bladder wall away from their attachment to the intravesical ureter. The line of cleavage is easily located and one is surprised by the ease with which separation takes place. The mucous membrane
presents itself, is opened, and the ureteral orifice with catheter in place is plainly visible. The posterior attachment is then separated in a like manner, the ureteral catheter withdrawn from below, and the ureter including the ureteral meatus removed in one piece. The defect in the bladder measures not more than 1 cm. in diameter and is closed with O-chromic cat-gut. The wound is closed in layers, with drainage. Bladder drainage is maintained by a urethral catheter.

The procedure as here described has purposely not taken into account the upper ureter or kidney, but offers a method of handling the lower segment of ureter which may be applied in primary nephroureterectomy, uretero-nephrectomy or secondary ureterectomy. In the two instances in which I have used the technique, both patients had had a previous nephrectomy.

The first patient, a male, age 62, was first seen in February, 1940, with a story that eleven months before, his left kidney had been removed because of bleeding, the bleeding persisting, however, after operation. Cystoscopic study revealed the source of bleeding was from the stump of ureter and from the ureterogram a diagnosis was made of primary carcinoma of the ureter or a papillary tumor secondary to an epithelial neoplasm of the renal pelvis. Repeated attempts to obtain a pathological report of the removed kidney were unsuccessful. On February 26 a left total ureterectomy was performed employing the technique described above. The specimen removed revealed a medullary carcinoma of the ureter. Cystoscopy on the 16th postoperative day showed a normal bladder, the defect entirely healed, with only a pale scar in the location of the left ureteral orifice. Check-ups at regular intervals to the present time have shown no evidence of recurrence.

The second patient was a female, age 65, upon whom a nephrectomy was performed in October, 1939, for a papillary carcinoma of the renal pelvis. Eighteen months later she developed a recurrence of her hematuria and examination revealed three filling defects in the lower ureter about 2 cm. from the bladder which were felt to be transplantations. On April 14, 1941, a total ureterectomy was performed through a left inguinal incision, the ureter being exposed extraperitoneally. Using the above technique, the bladder wall was
separated from its attachment to the outer wall of the intra-vesical ureter and the entire stump of ureter, including the meatus, was removed in one piece. Exposure was excellent and the ureteral orifice could be plainly visualized. The defect in the bladder wall was quite small and was closed with O-chromic catgut, the wound being closed in the usual manner and bladder drainage maintained by a urethral catheter. The specimen removed revealed three small papillomata in the lower end, sections showing papillary carcinoma grade 1. The urethral catheter was removed on the eighth day, patient voided normally and she was discharged on the sixteenth day. Cystoscopy one month later revealed a negative bladder, the defect perfectly healed and no sign of a ureteral orifice on that side.

Comment

The difficulties and hazards in lower ureteral surgery present in the minds of some surgeons are, I believe, over-estimated. Attention to a few details such as the use of the ureteral catheter and having the bladder completely empty greatly facilitates the ease of operation. An empty bladder not only provides better exposure of the lower ureter but prevents spilling of bladder contents into the wound. In my own experience the lower third of the ureter is the most accessible portion in the surgical removal of ureteral calculi, a mid-line suprapubic incision being employed almost routinely.

Conclusions

1. Papillary growths of the renal pelvis and ureter demand complete extirpation of the kidney and ureter. Especial emphasis is placed on the proper method of dealing with the intravesical segment, as it is essential that the last vestige of ureteral mucosa be removed.

2. The proposed technique of extravesical removal of the intramural ureter affords a method of accurate dissection of the intravesical segment including the ureteral orifice, under direct vision.

3. Two cases are reported, one a primary carcinoma of the ureter and the other a papillary carcinoma of the ureter, in which the described technique was successfully employed.
The Patient and His Hospital†

FRANK BRADLEY, M.D., '28*

Hospitals are not new. Their history dates back to the early Greek days. Here in the United States we have had them since 1732 when the Philadelphia General Hospital, under the name of Blockley, was established. The modern hospital is a place of comfort and good cheer. Its distinguishing features are its contribution in furnishing medical care, nursing care, shelter for the patient and facilities to the doctor. I should like to quote these words by Dr. Yandell Henderson:

“To overthrow superstition, to protect motherhood from pain, to free childhood from sickness, to bring health to all mankind. These are the ends for which throughout the centuries the scholars, heroes, prophets, saints and martyrs of medical science have worked and fought and died.”

These words give the creed of the hospital. Only a brief consideration of this creed shows that it is identical with the purpose of Christianity, and throughout it runs a refrain of human kindness which after all is an expression of love for our fellow man.

The development of the hospital was relatively slow until the middle of the nineteenth century when Louis Pasteur showed conclusively that germs are definitely the cause of many diseases, Lord Lister did his great work on asepsis, Florence Nightingale started the first school of nursing and anesthesia was developed. These four great things gave the modern hospital a tremendous impetus forward. Progress was still slow, however, until the turn of the twentieth century, yes, even until after the first World War. At this point the hospital took a part in the tremendous expansion of all American institutions, but I think that there is one further explanation of the rapid growth of the modern hospital. It is that the hospital does offer a definite service to the community in the care of sick and injured persons.

† Address given on Civic Forum over radio station KFUO.
* Superintendent, Barnes Hospital, St. Louis, Mo.
A great part of the hospital care and a most important part is nursing. The duties of a nurse are, of course, to help the physician alleviate pain, cure disease and cheer the patient. The functions of a nurse are of a varied character requiring versatility, a sense of humor and tact. She is daily thrown with all sorts of people; high and low, good and bad, rough and gentle. The success of the nurse depends more upon her skill and tact in these relations than in anything else. Her task requires fidelity and industry. Yet neither of these finally avails unless the nurse possesses the instinct of order and system. The ability to work is essential. From this you can understand why we select our nurses so carefully and train them as we do. What has been said about the functions of a nurse might just as well apply to the physicians, intern and other hospital personnel.

The hospital is learning to carefully instruct their personnel in the practical psychology of the patient, and the most important thing for the employee to possess is tact. You know that good manners develop good public relations. The first practical approach to you, the public, is to have you believe that we are sincere, and this approach, we believe, begins with simple, rugged courtesy and kindness. Kindness is not something that you can put on or take off as you would a coat. It is something that we must have as a part of us, and something which in a great measure is inherent in us. We can by consciously thinking that we will be kind to everyone so make it a part of our every day lives that we radiate kindness. It is our belief that kindness is the key to humanizing the hospital. We stress to our personnel that kindness begins not only with the patient, but with everyone with whom he comes in contact—with his fellow worker, with the doorman, with the information clerk, with the student nurses, and in the case of the doctor, with the intern and with medical students following behind him. In fact, in all of the many personal contacts that are made in the employee's work in the hospital.

Why do we give you these facts? The reason is simply that you should be in a position to place a value on the type of service and the institution. We know that your psychology as a patient is affected greatly by the way you are managed. You appreciate being treated as an intelligent human being.
If you are given to understand why a certain thing must be done for your condition, you will remain cooperative in most cases even though you may be disappointed of a cure. This policy of treating you as an understanding, intelligent individual is one of the foundations of patient relationship in the modern hospital. I am not referring to talking down to you as if you should be grateful for attention. I mean discussing matters with you in such a way that you will appreciate our recognition of your rights to be told the answers to what you want to know. Of course, we must always gauge your ability as a patient to be told a certain amount, but that applies to the individual instance.

As another aid in helping you appreciate what goes on in the hospital, I should like to tell you some of the instructions that we give to our interns. We tell them that in dealing with patients they should learn a reasonable amount of humility because many of you who are patients are people of importance in some field or another—in business, in sciences allied to Medicine or other professions. You have a definite opinion if you are at all a successful man or woman, and the wise doctor listens to your opinions and challenges them seldom. The day has passed when you, the public, believe that hospitals are invulnerable and infallible. The hospital is responsible for your change in attitude because we state that the practice of Medicine is so complex today that it is a task which no single physician can carry out alone, and for that reason there are many specialties.

The very complexity of the hospital service caused by the rapid advances in medical science, increased use of diagnostic facilities of the hospital, the change in our mode of living from homes to apartments, hotels, cities and our improved transportation system, particularly due to the automobile and the airplane, has shifted the population from the rural to the urban centers. The hospital is becoming more and more the essential factor in medical care. We are seeing a rapid transition from the simple nursing home type of hospital to diagnostic and treatment centers. An education phase has been added. We now give instructions to interns, nurses, medical students, dietitians, laboratory technicians, and what is very important, to you the public. Research in medicine and hos-
hospital management is always being carried on. This is true today, even in the smallest hospital in the community.

The increased cost of diagnostic services which the doctor needs today, particularly x-ray and laboratory facilities, are such that the doctor cannot afford to continue to have them in his private office, and the result is that he is looking toward the hospital more and more for these services. The modern hospital is now the long arm of the physician. A most important feature of service to the physician is the interne or house physician. Without him, the modern hospital could hardly function today.

To return to the practical psychology of the patient, in all of us when we become ill there looms a great spectre of fear. There is a forceful weapon against that dread spectre, and that is hope! Both fear and hope are dangerous and must be used skillfully and cautiously. To build up a patient's hope falsely is the cruelest type of mental torture of which I can conceive. However, to inspire the patient with hope is part of the psychological, mental and medical victory. As I have pointed out before, another practical part of this battle against fear is our ability to have the patient believe in our sincerity. The sick person who comes to the hospital for medical aid is usually not in a happy frame of mind. He knows that an effort will be made by the hospital and the doctor to relieve his suffering and to restore him to his former self. But he is intrusting himself to strangers and he looks eagerly, but perhaps not too hopefully at first, for signs of personal sympathy.

In considering the patient's state of mind, other mental states which we should watch for besides fear are anxiety which is closely related, weariness, depression, shame, loneliness and irritation. Not all of the responsibility or ability to win the patient's confidence and allay his anxiety rests with the physician. A great measure of it rests with the hospital. You will find that beginning with the information desk and the admitting office, the hospital throughout all of its departments keeps the mental state of the patient in mind. May I suggest that should any of you have the misfortune to become patients that you learn as much of the working of these departments of the hospital as you possibly can. It will help you a great deal in your handling of your problem and more
often when your friends and relatives are ill and in the hospital, it will help you in making their burden lighter.

We are faced by so many complexities today that it is difficult for us to see the way. The trite saying is that one cannot see the forest for the trees. It is not enough that these complexities apply to the rapidly changing science of medicine but they also apply to our economical and social life. Today war stares us in the face.

The voluntary hospitals are your hospitals and you should know their value and the type of service they can give you. You must know their condition and needs and recognize your responsibility to them. The voluntary hospital—the one you want to go to—is a non-profit, purely service institution serving the average citizen. To exist they must depend on what you can pay, plus gifts from friends, income from endowment and community giving.

You should be told that in the St. Louis area there are not enough beds in your voluntary hospitals. There is no need for more hospitals. The twenty-two hospitals we have are entirely adequate if they can but expand their bed capacity. Give them your support. Group Hospital Service, which is also a non-profit, purely service voluntary hospital plan, has enabled many to have hospitalization who otherwise could not have received it. This alone has created a demand for more hospital beds.

Here is a paradox—not enough hospital beds and yet the rejection of draft registrants by the armed services is 43 per cent. This is higher than it was in the first World War when it was 31 per cent. Of the 43 per cent who are rejected, let us analyze the figure: 8 per cent are due to defected teeth, which cannot be charged to lack of medical or hospital facilities. 5 per cent are due to eye conditions. 2 1/4 per cent to ear, nose and throat. 2 per cent to hernia. 1.4 per cent to foot diseases. 1.3 to overweight and underweight. These are conditions that can easily be corrected by some simple treatment or minor operation. A large number of these men can pass the physical examination if they make an effort. Unfortunately, only a few will do so of their own accord. Why do they not do so? The principal reason is probably the cost of treatment and trouble involved, and certainly ignorance is a major factor. This is a challenge to our democratic principle.
What is the answer? We need your support of the voluntary institutions and your help with an education program to make us physically fit.

One cannot forget the present war. If war should come the hospital burden will fall on our community hospitals and not on army hospitals. When bombs fall, it is the civilian population that suffers the most casualties, not the army. The coastal cities would be bombed first. Their hospitals would be crowded with severely injured and the regular and overflow patients would need to be evacuated inland to cities like St. Louis. For that reason the constant readiness of our civilian hospitals and their well-being and support by the community is of paramount importance, not only to conserve our greatest national asset, our health, but for the patient.

Attention!

The Alumni Office is experiencing great difficulty in keeping track of alumni who are now in service. If you are one of this number, or if you know of someone who is, it would be very much appreciated if you would write and tell us, giving rank, station, etc. The blank in the back of the QUARTERLY can be used for this purpose.
William Norman Beggs — 1862 - 1941

Dr. William Norman Beggs, born in Rolla, Missouri, December 10, 1862, died October 31, 1941, at the Swedish Sanitarium in Englewood, Colorado, after a long illness. His death followed by less than a week that of his wife Elizabeth.

The passing of Dr. Beggs has taken from Denver one of the greatest pioneers in tuberculosis that this region has had. When Dr. Beggs moved to Denver forty-four years ago, he brought with him microscopes and other medical equipment that this part of the country had never seen before. His work in bacteriology, histology, and pathology at the St. Louis Medical College along with his training at the University of Kiel made him one of the outstanding men of his day.

Even though he moved to Denver because of tuberculosis, he was able to live a long, useful life. His life in Denver has been given not only to the Medical world, but to our state historical and natural history societies.

He was a wonderfully well read man in medical and allied fields and possessed one of the most complete personal medical libraries of any doctor in the Rocky Mountain region.

It is to be noted that through the cooperation of Dr. John Zarit, this entire library of many rare, valuable, and obsolete journals has now been given to the Denison Memorial Library at the University of Colorado Medical School.

It has been said of this noble philanthropist that he has fulfilled Micha’s test of what is good, “to do justly, to love kindness, and to walk humbly with my God.”

Dr. Beggs is survived by his sister Miss Gertrude Beggs of Lyons, Colorado, and a brother Charles in California.

His remains were buried at his birthplace, Rolla, Missouri.

RALPH M. STUCK, M.D. '32.
DEPARTMENTAL CONFERENCES

Pathology

History No. 45202. A 74 year old white woman entered the hospital on October 19, 1941 complaining of anorexia for six months, of constipation, constant pain in the right lower quadrant of the abdomen, and an enlargement of the abdomen for three months, and of dyspnea for two months. She also had nocturia for about six months and swelling of the ankles for two months. Family, social and past histories were essentially negative. She had used no alcohol.

Physical examination revealed an enlargement of the heart with no murmurs. The pulse rate was eighty per minute. The blood pressure was 160/90. The abdomen was markedly enlarged and contained fluid. There was no abdominal tenderness. There was pitting edema of the thighs, legs and feet. On pelvic examination, a mass was felt in the left adnexal region.

A complete blood count and urinalysis were negative. On September 15 the venous pressure in the arms was 135 mm. of water. On September 17 the venous pressure was 220 mm. of water. The diagnoses considered most strongly were cirrhosis of the liver, cardiac decompensation and ovarian cyst. The patient died on September 20, 1941.

Autopsy No. 9421. The liver weighed only 1050 grams and was firm in consistency. The parenchyma generally was composed of greenish brown nodules varying from 3 to 20 millimeters in diameter. Strands of dense fibrous tissue were between the nodules. Scattered through the organ were several poorly defined, greenish white, only moderately firm nodules of tumor. Masses of firm, gray tumor-tissue varying from 5 to 20 millimeter in diameter were scattered over the peritoneal and pleural surfaces and the abdominal lymph nodes all contained tumor. The peritoneal cavity contained 20,000 cc. of serosanguinous fluid. The gall bladder had a thickened, contracted wall and contained several calculi varying from 5 to 15 mm. in diameter. The extrahepatic bile ducts were normal.
Microscopically the general architecture of the liver was destroyed. There were variable sized masses of liver cells with eccentrically placed or no central veins. The masses were separated by broad strands of dense fibrous tissue in which were many lymphocytes and bile ducts. The masses of tumor in the liver were composed of a fibrous stroma through which were scattered numerous anaplastic cells which tended to form acini. There were numerous mitotic figures. The masses of tumor on the serous surfaces and in the lymph nodes were similar microscopically. Diagnosis: Cirrhosis of the liver, carcinoma of the liver (bile duct type) with metastases to peritoneum, pleura, and to abdominal lymph nodes.

Discussion: The association of the carcinoma of the liver with cirrhosis of the liver in this patient illustrates the definite relation between these two conditions. In approximately 90% of carcinoma of the liver of the liver-cell type and 60% of the bile-duct type there is a cirrhosis. On the other hand, in about 4 to 6% of cirrhosis of the liver there is, in addition, a carcinoma. The recent investigation on the production of tumors of the liver with butter yellow and the relation of vitamins to these tumors have given important information on the early stages of carcinoma.

History No. 92243. A 43 year old rock-breaker entered Barnes Hospital September 14, 1941. Two weeks before entry he had begun to feel tired, listless. A week later he noticed severe headaches, and had two chills following which his temperature reached 104 F. Severe backache and joint pains accompanied the other symptoms. Two days later he developed a constrictive feeling in his chest, and began to cough, producing a thick, sticky sputum. He was treated with quinine by his doctor, who believed the patient had malaria. Four years before the present illness, the patient had experienced abdominal pain with tarry stools, and had been told that he had an ulcer. There had been no pain since that time. The patient’s milk supply was unpasteurized. A history was obtained of contact with a dead rabbit two weeks before the onset of the present illness.

Physical examination on admission to the hospital revealed enlargement of the left axillary lymph nodes, impaired reso-
nance and suppressed breath sounds over the lower lobe of the right lung, a slow (80) dicrotic pulse, and moderate epigastric tenderness.

Laboratory examination revealed 4,600,000 red cells and 9,200 white cells per cubic millimeter of blood. The differential count was: stabs 34%, polymorphonuclear leucocytes 54%, lymphocytes 5%, monocytes 6%, and basophilic leucocytes 1%. The examination of the urine and the Kahn reaction were negative. Agglutination tests with the organisms of the typhoid, paratyphoid and brucella groups, were negative, as was agglutination with Proteus X-19.

Shortly after admission, the patient showed some cyanosis and increase in respiratory rate, and was placed in an oxygen tent and started on sulfadiazene. Sputum culture showed Micrococcus catarrhalis and a few pneumococci. On the third day, the patient had two small coffee-ground emeses, and a tarry stool. Thoracentesis yielded 650 cc. of cloudy fluid with specific gravity of 1.012, and 3,200 cells per cubic mm., of which 50% were lymphocytes and 50% polymorphonuclear leucocytes. The patient received three transfusions of whole blood.

On the ninth hospital day, the patient suddenly experienced severe lower abdominal pain. He went into shock, and died in a few hours. Agglutination tests with pleural fluid reported after death were positive for Pasteurella tularensis up to 1:320.

Autopsy No. 9425. The lungs were greatly enlarged weighing 2700 grams. There was a necrotizing pneumonia of the middle and lower lobes of the right lung. In some areas organization was present. The spleen and liver were studded with minute caseous white foci, varying in size from 1-3 mm. in diameter. In the stomach there were two ulcers on the anterior wall. One of these measured 35 mm. in diameter and was perforated in its pyloric portion into the free peritoneal cavity. The peritoneal cavity contained gas and coffee-ground material. There was an early serofibrinous peritonitis.

Discussion: On the basis of the autopsy findings it is clear that this patient had tularemia acquired by contact with the dead rabbit, about two weeks before the onset of the illness. The immediate cause of death was the perforation of a pre-existing gastric ulcer and an exsanguinating hemorrhage. The
relation between the two diseases is not clear. It is possible that the tularemia brought about excessive necrosis in the bed of the chronic ulcer.

History No. 89865. A 50 year old boilermaker entered the hospital on June 2, 1941 complaining of a productive cough, hoarseness and loss of weight. For one year he had had repeated attacks of hoarseness, and the cough had gradually become more noticeable and annoying. On several occasions the purulent sputum had been blood-streaked. Weakness and fatigability gradually became a major symptom.

Upon physical examination he was pale and emaciated. There was flatness to percussion over the left hilar region posteriorly and throughout the chest were coarse rales. The left true vocal cord was fixed in the midline when seen upon laryngoscopic examination. An X-ray film of the chest showed enlargement of the hilus of the left lung. By bronchoscopy a diagnosis of carcinoma of the left main bronchus was made but the biopsy was unsatisfactory.

He was discharged unimproved but returned in 18 days complaining that for two days he had suffered paroxysmal attacks of coughing when he attempted to swallow food. X-ray film of the chest showed that swallowed lipiodol appeared in the left main stem bronchus. Signs of bronchopneumonia became evident and he died within two days. The clinical diagnoses were bronchogenic carcinoma, broncho-esophageal fistula, and paralysis of the left vocal cord.

Autopsy No. 9288. In the posterior wall of the left main bronchus was an opening 30x15 millimeters which communicated with the lumen of the esophagus. The margins of the opening of the bronchus were composed of dark green, somewhat friable, shaggy tumor tissue which extended to involve the entire circumference of the bronchus in a segment 3 cm. long. The mass extended into the mediastinum under the arch of the aorta for 7 cm. and invaded the parietal and visceral pleura of the left lung. All of the mediastinal lymph nodes contained metastatic tumor tissue. There was broncho-pneumonia in both lungs.

Microscopically the tumor was composed of cells showing advanced pleomorphism, many mitotic figures and tumor giant
cells. The cells were in nests and islands which were necrotic in several areas. The anatomical diagnoses were: Carcinoma simplex of the left main stem bronchus with direct extension to the mediastinum, to the esophagus, and to the pleura; metastases to the bronchopulmonary lymph nodes and to left lung; bronchopneumonia.

Discussion: This is a typical instance of carcinoma of the bronchus with perforation into the esophagus. The tracheoesophageal fistula produced the characteristic symptom of persistent coughing during the last few days of life. The bronchopneumonia is probably an aspiration type of pneumonia.

A 27 year old housewife was admitted to the medical service of Barnes Hospital with the complaint that 6 months previous to entrance she had an attack of cramping pain in the right upper quadrant which radiated to the back and was accompanied by nausea and vomiting. This lasted for one week. Three weeks previous to entrance she developed the same symptoms. During the following two weeks the patient developed anasarca and jaundice. This was not accompanied by fever. The past medication consisted of ox bile and morphine. Past history revealed that the patient had received an inadequate diet for one year.

Physical examination revealed icterus, generalized edema, ascites and flaking of the skin at the corners of the mouth and eyes. The liver could not be percussed or palpated. There were a bilaterally positive Hoffmann's sign and hyperactive reflexes.

The laboratory findings were: 3.5 million red cells; 12,000 white blood cells; and a normal differential. The urine contained albumin, bilirubin but no urobilinogen. The stools contained no stercobilin. The Kahn reaction was negative. The NPN was 19 mgs. % and the icteric index was 60. The blood sugar was 52 mgs. % and the prothrombin time was increased.

The patient was given a high carbohydrate diet, and parenteral vitamins. In addition she was given liver extract, choline, and vitamin K. The patient developed somnolence, mild convulsions, and went into coma dying on the fifth hospital day. Findings on the fourth day were: tyrosine crystals in the urine, low urea nitrogen, normal NPN, increased prothrombin time in spite of parenteral vitamin K.
Clinical Impression: Subacute Yellow Atrophy of the Liver. Washington University Autopsy No. 9441. The essential findings at autopsy were in the liver. The liver weighed 700 gms. There were yellow, raised, nodular foci containing normal liver markings. Between these foci there was red tissue containing minute white strands and no liver markings. Numerous sections revealed about $\frac{1}{3}$ of the liver structure was present as the yellow areas and the remainder was destroyed. There were 5000 cc. of clear yellow fluid in the peritoneal cavity. Microscopic study of the liver revealed regeneration of the liver in the yellow foci with many of the hepatic cells containing three nuclei. The red foci contained fibrous tissue only.

Discussion: At autopsy only about one-third of the total hepatic parenchyma was identifiable. This finding is directly related to the clinical appearance and laboratory determinations. There were icterus, edema and ascites on physical examination, and the laboratory determinations showed a low blood sugar and a low plasma prothrombin. All of these point to severe hepatic damage.

A 33 year old white man, W. P. A. laborer, was well until 6 A. M., September 28, 1941 when he was awakened by a severe constant substernal pain which radiated down both arms. He was brought into the St. Louis County Hospital at 7:55 A. M. On admission he was comatose, cold, and cyanotic, and his respirations were gasping in character. He was given stimulants but he died five minutes after admission. The clinical diagnosis was coronary occlusion.

Autopsy No. 9428. The heart was moderately enlarged, weighing 490 grams. The myocardium was firm and reddish-brown in color. The valves and valvular rings were normal. The intima of the sinuses of the valsalva, the arch of the aorta and the thoracic aorta was irregularly thickened by numerous pearly white translucent plaques with wrinkled and puckered surfaces, which measured 5 to 20 millimeters in diameter. These plaques in the intima of the sinuses of the valsalva almost occluded the orifices of the coronary arteries. The orifice of the left coronary artery measured 0.5 millimeter in diameter and the orifice of the right coronary artery measured 1
mm. in diameter. The intimal surfaces of the coronary arteries were normal. Microscopic examination of the wall of the aorta showed a marked perivascular infiltration of lymphocytes and plasma cells. There was an endarteritis of the vasa vasora. In the media there was destruction of the elastic tissue wherever there was a focus of perivascular infiltration. Some of these foci were completely replaced by dense fibrous tissue around the peripheral margin of the infiltration. The intima of the aorta was thickened by fibrous tissue.

Diagnosis: Syphilitic Aortitis with Stenosis of the Orifices of the Coronary Arteries Advanced, (History of Sudden Death). Hypertrophy and Dilatation of The Heart.

Discussion: Syphilitic disease of the aorta may lead to a number of complications, notably aneurysm and valvulitis with insufficiency at the aortic orifice. One of the rare complications is illustrated by this case; stenosis of the orifices of the coronary arteries. This comes about slowly. A collateral circulation is established through pericardial vessels and through the Thebesian veins. The end result is similar to that of severe arteriosclerosis with thrombotic occlusion of the coronary arteries except that an infarct rarely forms.

Pediatrics

LEAD POISONING IN INFANCY

DR. JOHN H. DOVAL

From the St. Louis Children's Hospital and the Department of Pediatrics, Washington University School of Medicine.

During one of the October Thursday Morning Pediatric Conferences, the following case was presented as one of probable lead poisoning and the subject was reviewed:

J. O., a boy of 18 months, was brought to the hospital because of severe projectile vomiting and stupor, of approximately twelve hours' duration. Prior to the onset of these symptoms, he had apparently been well except for some irritability and constipation. He had, however, chewed most of the paint off of his crib during the previous nine months. Examination, in addition to stupor and vomiting, revealed the following: (1) A severe hypochromic anemia (red blood cell
count 4,800,000, hemoglobin 6.3 grams or 43 per cent) with anisocytosis, poikilocytosis and uneven distribution of hemoglobin in the cells but without, however, basophilic stippling; (2) hypertension (arm 130/80, leg 170/90); (3) questionable papilledema, which became definite after several days; (4) slight increase of protein in the spinal fluid, which was otherwise normal; (5) negative spectroscopic test for abnormal amounts of lead in the blood but approximately ten times the normal amount of lead in the urine after sodium citrate had been administered as treatment; (6) suggestive leadline in bones. A sample of the paint from his crib was found to contain lead.

In reviewing the subject, the following points were brought out:

Lead intoxication is very serious not only because of a high fatality rate but also because of the likelihood of extensive and permanent damage to the brain. The high incidence between one and three years of age is due to the fact that the mouth is the chief portal of entry and that teething infants of this age may place almost anything in their mouths. Paint is the most common source of lead poisoning, but lead-containing ointments, lotions, face or body powders and insecticides have also caused lead poisoning. Even lead nipple shields have caused poisoning. Intoxication as the result of inhalation of lead fumes is also possible, two particularly severe epidemics having been reported recently from Boston and Baltimore, as a result of the burning, for home heating, of storage battery casings. The melting of lead and the molding of toy figures is also known to have caused severe intoxication.

For a proper understanding of the symptoms of lead poisoning and its treatment, a knowledge of the metabolism of lead is essential. In this respect lead closely resembles calcium. After absorption it is transported in the blood, where it seems to cause most of the acute symptoms. Some is eliminated from the body by excretion into the urine and into the intestine, while a considerable portion is deposited in combination with phosphate in various organs, but chiefly in the growing portion of the long bones, where it becomes physiologically inactive. Its deposition in the brain leads to intense edema, to symptoms of acute encephalitis with increase in protein in the
spinal fluid and to permanent changes such as internal hydrocephalus and cortical atrophy. In 130 cases reported by Mckhann, 55 per cent developed encephalopathy, 25 per cent dying and 35 per cent showing permanent neurological sequelae. Peripheral neuritis is less common in infants than in adults and when present may be masked by the encephalitis.

Since deposition into bone renders lead physiologically inactive, early treatment is usually designed to favor such deposition and includes the giving of food relatively low in calcium and high in phosphate, with an alkaline-ash and containing a large amount of Vitamin D. Because exacerbations of acute symptoms with subsequent deposition of more lead in the brain may occur if appreciable quantities of lead are mobilized from bone depots and again transported in the blood and because such mobilization results from infections, particularly if acidosis develops and is unpredictable and not easily controlled, attempts are often made during remissions of acute symptoms to “de-lead” such patients. Measures often used have been careful administration of parathormone and the production of mild acidosis. Recently evidence has been presented that sodium citrate may have a powerful solvent effect on tertiary lead phosphate deposited in the bones and other tissues and that a relatively unionized complex results, which can be safely transported through the blood and be eliminated by urinary excretion.

Such treatment was given to the infant reported and an increase of urinary lead and some improvement of symptoms were noted.

Attention!

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News of the School

David Preswick Barr Portrait and Lectureship

Shortly after it became known that Dr. Barr would leave Washington University School of Medicine, Dr. Frederick A. Jostes gave a dinner for Dr. Barr at River's Arm, his country residence, and all of his resident physicians, who could, attended.

At this very successful dinner, it was also decided to form a Residents' Committee to raise funds for the presentation of a portrait of Dr. Barr to the Medical School. The first and oldest of Dr. Barr's residents, Dr. Lee D. Cady, was elected to head the Committee. Dr. Leon Bromberg was selected as the Treasurer.

Dr. Barr graciously gave his time during the summer for Mr. Charles F. Galt to complete the portrait. It has been viewed by the Residents' Committee and pronounced an excellent likeness of the "original."

The funds are almost all in. The contributions have been made to date exclusively from interns and former house officers who have served under Dr. Barr during the past seventeen years.

If it can be arranged to have Dr. Barr present in St. Louis again to meet his former house officers, the faculty, and his numerous friends, a presentation ceremony and dinner is contemplated for a later date during the school year.

On Marking the Grave of Dr. Joseph Nash McDowell

It is with some satisfaction that we are able to report that the minimum sum of money estimated to cover the cost of erecting a marker at the grave of Dr. McDowell and for perpetual care of the cemetery lot has been subscribed. The statement of the Boatmen's National Bank of St. Louis of October 31, 1941, shows a balance of $412.58 to the credit of the Dr. Joseph Nash McDowell Memorial Fund. We are grateful to the 200 physicians who have responded to the call to mark the McDowell burial place, alumni of the Missouri Medical College, graduates of Washington University, St. Louis University and of several schools away from St. Louis. The Belle-
fontaine Cemetery Association has given permission to carry out our plan. A design for the monument has been chosen and work on the stone is well advanced. It is our expectation that the monument will be placed before the end of the present year, the one-hundredth since the graduation of the first class of the Medical Department of Kemper College. Efforts are being made to bring this about and as speedily as possible to set the day for the ceremony of unveiling.

COMMITTEE
Robert E. Schlueeter
John Zahorsky
Robert J. Terry

Since the Quarterly was sent to press the McDowell monument has been completed and placed in Bellefontaine Cemetery.

R. J. T.

The Medical Library

Miss Judith Wallen Hunt, librarian of the Bio-Medical Libraries of the University of Chicago, was a recent visitor in the library.

In July the library had a visit from Dr. A. F. Piraino, of Oberlin, Ohio.

Mr. Scott Hancock of St. Louis brought Mr. Deane Keller of New Haven, Connecticut, to see the Beaumont collection. They were looking for a portrait of Dr. Beaumont, and we were able to show them the original Chester Harding. They spent a short time looking over the Beaumont manuscripts and the case of Beaumontiana which are on display in the Beaumont room.

Dr. Harvey Lester White and Dr. Hubert Peugnet, who were home on leave from Camp Robinson, Little Rock, Arkansas, paid the library a visit.

Other visitors were Dr. Frank B. Queen, '38, of Chicago and Dr. Leonard F. Bush, '34, of Danville, Pennsylvania.

Dr. Arnold Welch, of Philadelphia, was in the library for a short visit.
The library has purchased the following books:
Cummings, R. O. The American and his food. Chicago, 1940.
Eddy, W. H. What are the vitamins? N. Y., 1941.
Krogh, A. Comparative physiology of respiratory mechanisms. Philadelphia, 1941.
Krogman, W. M. A bibliography of human morphology. Chicago, 1941.
Mark, H. F. Physical chemistry of high polymeric systems. N. Y., 1940.
Nord, F. F. & Weidenhagen, R. Handbuch der enzymologie. Leipzig, 1940. 2 volumes.
Sherrington, Sir Charles S. Man on his nature. N. Y., 1941.
Hammett, Louis P. Physical organic chemistry. N. Y., 1940.
Lennox, William G. Science and seizures. N. Y., 1941.
Reynolds, Samuel R. M. Physiology of the uterus. N. Y., 1939.
Sherman, Henry C. Chemistry of food and nutrition. 6th ed. N. Y., 1941.
Sherman, Henry C. and Lanford, Caroline S. Essentials of nutrition. N. Y., 1940.
**Gifts**


Carlson, E. R. Born that way. N. Y., 1941. Gift of Dr. B. S. Veeder.


Eddy, W. H. What are the vitamins? N. Y., 1941. Gift of Dr. Veeder.


**In Memoriam**

Calbert H. Beach, Mo. '89, Glencoe, Oklahoma; died May 15.

Charles M. Brookings, Mo. '98, Duquoin, Illinois; died March 9.

William N. Beggs, Mo. '86, Denver, Colorado; died October.

Clarence Edgar Edwards, Mo. '74, San Francisco, California; deceased.

Max A. Goldstein, Mo. '92, St. Louis, Mo.; aged 71, died July 27.

M. George Gorin, Mo. '95, St. Louis, Mo.; aged 70, died June 27.

Joseph A. Hardy, Mo. '92, St. Louis, Mo.; died October 14.

William G. Harwood, Mo. '82, Dover, Missouri; aged 84, died January 28.

Philip J. Heuer, Mo. '95, St. Louis, Missouri; died March 8.

Tandy Allen Hughes, St. L. '83, Denver, Colorado; died November 2.

Hans Louis Kleine, '29, St. Louis, Missouri; fatally injured while on maneuvers September 21.

Harden T. Leach, '96, Elston, Missouri; aged 76, died March 30.

Bransford Lewis, Mo. '84, St. Louis, Missouri; aged 79, died May 18.

Ernest Oelfcken, '96, St. Louis, Missouri; deceased.

George Parrish, '94, Los Angeles, California; aged 69, died following abdominal operation August 7.

Eldon Phillips, Mo. '83, Cape Girardeau, Missouri; died May 21.

Squire H. Redmon, St. L. '80, Tipton, Missouri; aged 86, died May 7.

Forest H. Staley, '18, St. Louis, Missouri; died September 21.

Solomon Winchester Tickel, Mo. '90, Springfield, Missouri; deceased.

George W. Vinyard, Mo. '75, Jackson, Missouri; aged 91, died July 2.

C. C. Wright, '06, St. Louis, Missouri; aged 68, died June 10.
Alumni News

ROCKY MOUNTAIN CHAPTER HOLDS MEETING

The Rocky Mountain Washington University Medical Alumni held their second bi-annual meeting at the Canon Hotel in Yellowstone Park during the Rocky Mountain Medical Conference. All business was attended to briefly, after which a short resume of the activities at present at the School were reviewed by Dr. Alexis Hartmann, '21, Professor of Pediatrics at Washington University. Ten members were present.

A clipping from the Medical Pocket Quarterly lists S. T. Shelly, '83, of Mulvane, Kans., as a "champion baby doctor" and says that Dr. Shelly has ushered more than 4500 babies into the world since his graduation from Missouri Medical College. Each year he has a reunion of these babies, and at the last reunion more than 1000 were present.

G. D. Royston, '07, Professor of Clinical Obstetrics and Gynecology at Washington University School of Medicine, was installed as President of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons at their recent meeting in Hot Springs, Va. Dr. Royston is also President of the St. Louis Gynecological Society.

Edward H. Hashinger, '19, is practicing internal medicine in Kansas City, Mo., and is Professor of Clinical Medicine at the University of Kansas, Kansas City, Kan. He is co-author with Logan Clendening of "Methods of Treatment," C. V. Mosby, St. Louis. Dr. Hashinger holds the rank of Lt. Commander in the U. S. Naval Reserve.

George V. Feist, '23, Kansas City, Mo., was elected Grand Chancellor of Lambda Chi Alpha at its 19th General Assembly held August 26-29 at the Elms Hotel, Excelsior Springs, Mo. Lambda Chi Alpha is the fourth largest social fraternity in the United States, having 107 chapters and 28,000 members.

T. K. Brown, '24, Professor of Clinical Obstetrics & Gynecology at Washington University, was guest speaker at the centennial meeting of the Wisconsin State Medical Society at Madison on September 11. Dr. Brown lectured on "Treatment of Puerperal Infections" and "Management of Endocervicitis," and conducted a round table on "Treatment of Vaginitis." On September 23 Dr. Brown repeated his lecture on "Treatment of Puerperal Infections" for the Macoupin County Medical Society at Carlinville, Ill.

John A. Hartwig, '26, St. Louis, Mo., has been in general practice with a special interest in pediatrics, but was called to the Army last April. He holds the rank of Captain in the Medical Corps and is now stationed at Camp Robinson, Ark.

Clinton K. Higgins, '27, is a Lt. Comdr. in the Navy stationed at the Naval Hospital, Great Lakes, Ill.

Franklin Walton, '27, attended the Kansas City Surgical Society meeting on September 17 and spoke on "Wound Healing."

J. Lester Henderson, '29, has been at the Naval Hospital, Great Lakes, Illinois since April holding the rank of Lt. Comdr. Prior to that time, he had offices in Pasadena,
Calvin S. Drayer, '31, recently announced his entrance into private practice specializing in neurology and psychiatry with offices in the Medical Tower, 255 S. 17th St., Philadelphia.

Capt. Robert T. Terry, '33 is stationed in the Letterman General Hospital, San Francisco.

Leonard F. Bush, '34, Geisinger Hospital, Danville, Pa., was a visitor in the Alumni Room, October 3. Dr. Bush is married and has two children, a boy 4, and a girl 2.

James G. Telfer, '34, is at present stationed at the U. S. Marine Hospital in Chicago, after having spent two years abroad. In 1939 he was medical officer in charge of the Lai Chi Kok Cholera Hospital in Hong Kong, and in 1940 was ward surgeon of the Kowloon Hospital there. Also in 1940 he was a member of the medical survey made of the Burma Road for observation of the prevalent epidemic diseases. Dr. Telfer is married and has three children. His daughter, Margaret, was born in the Philippines in 1939, his son, Robert, was born in China in 1940 and his daughter, Patricia, was born in Chicago this year. While in Hong Kong he had to evacuate his wife and family twice and says, "As some Chinese might say, 'Chicago more better!'"

Elmer Graul, '35, is a 1st Lt. in the field unit of the Army and participated in the recent maneuvers held in California.

Henry W. Edmonds, '36, is resident in pathology at the Massachusetts General Hospital.

T. E. Kircher, '37, 1st lieutenant, MC, is assigned to the 48th Surgical Hospital at Fort Francis E. Warren, Wyoming.

Joseph H. Printz, '37, 1103 Grand, Kansas City, Mo., is in general practice with emphasis on surgery. Dr. Printz is on the surgical staffs of Menorah, St. Mary's, St. Joseph's and Research Hospitals. He is the proud father of a son, Richard, born June 15, 1940.

Dorothy Gill, '38, is beginning her second year as district physician on the District Service of the Boston Dispensary.

Roy Wm. Thomas, '38, is in general practice at 1726 Market St., Redding, Calif.

Floralou Kettenbach, '40, is resident in dermatology at Charity Hospital, New Orleans.

**Location for Practice**

Calhoun County, Illinois. Population, 26,000. Former doctor now in army. Contact Mr. Carl Franke, Batchtown, Ill.

University of Illinois Health Service. Two vacancies on Health Service Staff; a woman, $2400 per year, and a man, $3000 per year. Contact Dr. Howard Beard.

Hanna, Wyoming. Assistantship under a contract practice in coal mining town. 15 bed hospital. Contact Dr. R. M. Leake.

Crested Butte, Colorado. Contract practice with Colorado Fuel & Iron Corp. Ideal setup for doctor whose wife is a nurse. Private practice permitted. Salary $150.00 per month with modern office and equipment furnished. Contact Dr. W. B. Summers.
PLEASE CONTRIBUTE NEWS
for the Quarterly and Information for the Alumni Office
using the following form as a guide and sending your response
to Miss Louise Hunt, Washington University
School of Medicine

Full name (print) .................................................................
Class of .................................................................
Office address: number and street, town and state ..........................
Membership in medical and other scientific societies and offices held .................................................................
Field of work (as general practice, ophthalmology, public
health, pathology, teaching, investigation, etc.) ..........................
Connection with hospitals and schools .................................................................
Army and Navy (branch and rank) .................................................................
Papers published in present year (title, journal, volume,
pages, and date) .................................................................
Books published (give full title, publisher, place, date, number
of pages, illustrations) .................................................................

(OVER)
Editor or associate editor of medical or other scientific journal. Election to honorary societies (name of society and date of election). Honorary degrees, citations, medals, prizes

Member of scientific expedition, medical survey

Recipient of fellowship or of grant-in-aid of investigation

Connection with or activity in any other province of medicine not covered by the above

Have you a son or daughter entering the School next year?

Recent marriage—name, date and place

Recent birth—sex, date

Death—name, class, date of death, place

Desirable location for practice: town and state, number and street

Remarks

Write a letter of 200-250 words to the Quarterly for publication.

Please donate to the Library of the School of Medicine copies of books and reprints of papers you have published. You will confer a benefit to the Library and help to establish a record of the literary contributions of our graduates and faculty.
Washington University

George R. Throop, Ph.D., LL.D., Bridge Chancellor

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