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Dr. Wm. Otis Galbreath


When answering advertisements please mention THE JOURNAL OF OSTEOPATHY.
Chronic Articular Lesions—Type One.†

In this article we are to discuss the cause, nature, effect, diagnosis, prognosis and treatment of chronic articular lesions—Type One.

Cause:

This type of lesion is not due to extrinsic causes, such as infection, hemic intoxication, pernicious environal activities, trauma or morbid nervous reflex. On the contrary, so far as the lesion itself is concerned, its etiology is intrinsic. Such a lesion we shall term an idiopathic one, because it is a peculiar morbid process having its origin at the point of tissue involvement.

To be explicit, the cause of chronic articular idiopathic spinal lesions (i.e., chronic articular lesions—Type One) is lowered resistance of the body defences plus the constant, downward pull of gravity upon a point of inherited architectural weakness, a region of developed deformity or an area of broken functional compensation.

Bodily deformity, traumatic spinal lesions, reflex spinal lesions, individual postural defects, and disused or misused muscles anywhere in the body, often determine the location, extent and severity of this type of lesion. However, it must be borne in mind that structural perversions elsewhere in the body do not act directly to produce a chronic articular idiopathic lesion. Indeed, they are etiological factors only when they lower bodily resistance and at the same time displace the center of gravity so as to bring undue strain upon a weak point in the spine.

Nature (i.e., Pathology):

We know very little concerning the pathology of an osteopathic lesion. Thus far our laboratory investigations have dealt chiefly with the pathology of severe spinal injuries inflicted upon animals. As to the pathology of the form under discussion, nothing is known by the profession at large, because our literature does not treat concretely of the different forms of osteopathic lesions. So we can only speak tentatively in this article.

The writer has discussed the matter with Drs. Chas. Muttart, Wm. Nicholl and other well known osteopaths, and it is the consensus of opinion among those interviewed that, in a chronic articular idiopathic lesion, no gross structural changes take place in the affected idiopathic.
ence proves that this type of lesion yields more readily to treatment than any other chronic type.

Briefly stated, all clinical phenomena point to the fact that the most conspicuous pathological features of chronic articular lesions, Type One, are (1) Absence or marked diminution in the quantity of synovial fluid; (2) Drying of synovial membrane and capsular ligament; and (3) The firm adherence of the articular surfaces—due perhaps to the presence, in the earlier stages, of a plastic exudate.

In the cervical region, this type of lesion is often associated with rotation of the lesioned joint or joints. Low grade tissue deposits occur around the articular processes, chiefly on the side toward which the column above the lesion is rotated. These lesions, sometimes unilateral and sometimes bilateral, involve the articular surfaces between two or more vertebrae. When a group of three or more vertebrae are rotated toward the same side, curvature results.

The entire dorsal region is sometimes affected. However, the lesioned areas are usually the upper, the mid or the lower dorsal regions. One or more than one, region may be involved. This type of lesion, i. e., the chronic articular idiopathic type, almost invariably coincides with the points of developed spinal deformity*, for these osseous deformities represent weak points in the spinal column.

Idiopathic articular lumbar lesions are frequently associated with sacro-iliac lesions†. The latter may be either idiopathic, traumatic or sympathetic. Idiopathic sacro-iliac lesions are frequently overlooked, because innominate rotation is by no means a constant feature of this type.

Effect (Local):

No doubt the local effects of this lesion are similar to those of other chronic vertebral lesions.§ Movement in the lesioned joints as well as in the muscles attached to them is lost. One of the most important functions of a healthy muscle is constant vibration. This vibration, or alternate contraction and relaxation, exerts a powerful influence locally and generally upon the blood flow. When this normal function is lost, as in the case of a muscle attached to a chronically lesioned joint, local stagnation of blood and lymph occurs in the neighborhood of the lesioned tissues. The spinal cord and sympathetic ganglionic centers, situated in immediate proximity to the lesion, suffer impairment in consequence of this congestion. The efficiency of these congested centers grows less and less, until they are no longer capable of transmitting impulses normally between the brain and the related organs of the body.¶

Effect (Constitutional):

When vasomotor, trophic or other impulses fail to pass normally between the spine and the related viscera, as in the case of obstruction occasioned through spinal lesions, function is impaired in certain viscera presided over by the affected segment of the cord.!

Each spinal segment controls blood flow directly or indirectly to more than one part or viscus of the body; and of the organs or tissues presided over by a lesioned segment, those whose in-

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¶Deason: “Physiology,” 1913, see chapter LXIII.
¶McConnell: “Deason’s Physiology,” see Section IX, also see Section XI, by J. Deason.
intrinsic vasomotor mechanisms are weakest are the most markedly involved. This aspect of the matter is discussed at length in Chapter II of the author's treatise on "The Philosophy of Osteopathy."

In spinal lesions where the efficiency of neighboring nerve centers is lowered, afferent impulses being unable to pass normally via the cord to the brain, are deflected into abnormal nerve pathways. Thus, a long train of reflex symptoms often follows a spinal lesion of apparently insignificant proportions.

Now, experience has shown that the constitutional effects of idiopathic articular lesions is often far reaching and profound. Indeed, the severity of the symptoms noted appears to be out of proportion to the severity of the spinal involvement. Just why this should be is not clear. However, the fact itself suggests that the reflex arcs, not being structurally impaired, although rendered anemic through obstruction to their vascular supply, are abnormally responsive to irritation both external and internal.

Chronic idiopathic cervical lesions are responsible for many forms of headache, pain at the base of the skull, a sense of tension at the back of the neck, naso-pharyngeal catarrh, defective vision accompanied by pain or discomfort, functional heart trouble, mental depression, insomnia, pain that stimulates brachial neuritis high blood pressure, albuminuria, glycosuria, and so many other local or general symptomatic disorders that we have not the space to mention them here.

The most conspicuous and distressing symptoms that accompany chronic idiopathic lesions of the dorsal articulations are those of impaired nutrition and deranged metabolism. Patients thus afflicted are either overweight or underweight. In either case they suffer from general physical weaknesses and tire easily. The appetite is frequently impaired. There is either little or no appetite or an insatiable one. There are frequently present faulty digestion, constipation, chronic diarrhoea and painful distention of the stomach or intestines. Vague, indescribable fears, and at times a sense of impending doom, add to the distress of the sufferer. Albumen is present in badly nourished patients. The blood pressure may be normal, although it is abnormally high in some cases and abnormally low in others.

In the lower dorsal and lumbar regions we frequently find this type of lesion etiologically associated with prostatic enlargement, ovarian congestion, loss of abdominal tone, enterophtosis, uterine displacement, loss of sexual power, faulty carriage and gate, severe pains in the back, often extending the entire length of the spine, incontinence of urine, frequent desire to micturate, vasomotor disturbance of the lower extremities, varicose veins, etc.

Idiopathic sacro-iliac lesions are often responsible for sciatica, lumbago, backache, neurasthenia, dysmenorrhoea, fallen arch, joint stiffness, muscular pain and many forms of reflex pelvic disturbances. Indeed, this lesion frequently sets up pernicious reflexes that disturb cranial, thoracic and abdominal functions.

In short, chromoc articular idiopathic lesions, while not in themselves directly responsible for organic destruction and general physical decay, nevertheless cause such widespread suffering, and lead to such serious consequences, that our profession can ill afford to overlook their clinical significance.

Diagnosis:

Let us bear in mind that impaired joint function is invariably present in every osteopathic lesion, no matter what the nature or cause. Tenderness under pressure and stiffness upon active or passive movements may or may not be
present. Also mal-approximation of joint surfaces occurs in a reasonably large percentage of the various forms of spinal lesions. So we cannot look upon one or more of these physical signs and symptoms as characteristic of any one type of lesion.

However, if the physician considers the history of the case, studies the configuration of the spine as a whole, notes the absence of certain symptoms that are constantly present in other forms of articular perversions. and observes the effect upon the spine of the first few treatments, he will have little difficulty in distinguishing between an idiopathic articular lesion and other types of spinal involvement.

Idiopathic articular lesions usually involve a group of three or more vertebralae. The spine as a whole, presents a decidedly faulty configuration. That is to say, a configuration that seems but poorly adapted to sustain the body weight. The lesioned area, if curved at all, usually curves anteriorly or laterally in the cervical region, posteriorly in the dorsal region, and in the lumbar region sags anteriorly until the lower lumbar vertebrae form a "V" shaped depression with the sacrum. Absence of the normal dorsal convexity is by no means uncommon in this form of involvement. There is often a history of typhoid or other acute infection, after which health failed to return. Not infrequently the deterioration in health is gradual. However, sooner or later, the nervous system shows marked functional disturbance. The disturbance of organic activity is much less pronounced. After a few treatments the adhesions between the articulating surfaces show signs of giving way, and in an incredibly short time motion returns to the affected joints. After several weeks' specific treatment, the spinal configuration as a whole suggests greater efficiency than at the beginning of the treatment.

**Differential Diagnosis:**

To establish unmistakably a diagnosis of idiopathic articular affection, the examiner must differentiate between this type of lesion and the following types, viz:

- **Chronic Articular Lesions—**
  - Type Two—(reflex or sympathetic).
  - Type Three—(rheumatic or gouty).
  - Type Four—(traumatic).

- **Chronic Muscular Lesions—**
  - Type One—(idiopathic).
  - Type Two—(reflex or sympathetic).
  - Type Three—(rheumatic or gouty).
  - Type Four—(traumatic).

- **Compensatory Lesions.**
- **Unclassifiable Lesions.**

**Chronic Articular Reflex or Sympathetic Lesions:** When this type exists, the patient presents a history of long-standing organic disturbance. Improper diet and overeating play an important etiological role. The spinal muscles at the point of articular lesion are either non-resilient, dense or markedly atonic. The original visceral disturbance persists in subacute or chronic form, while secondary reflexes from the spinal lesions augment the severity of coexisting conditions and at the same time react upon the nervous system. These lesions do not yield readily to treatment, although the first few treatments may show marked organic relief. However, a long course of treatment is required in the majority of cases to remove the reflex spinal lesion and the associated organic symptoms.

**Chronic Articular Rheumatic or Gouty Lesions:** These lesions, as the name implies, are associated with a gouty diathesis. They more often cause pain...
and stiffness in the spine than disturbance elsewhere in the body. Persistent and careful treatments are required to remove them, and they have a decided tendency to recur. That is, until the rheumatic condition is eradicated through proper diet, exercise and habits of life.

**Chronic Articular Traumatic Lesions:**
In this type of lesion, the history of trauma, the limited extent of spinal involvement and the presence of inflammatory exudes around the lesioned joint are in themselves sufficiently diagnostic. Specific treatment applied with skill is necessary to overcome such a lesion. If of long standing, its reduction is no easy matter.

**Chronic Muscular Lesions:** In true chronic muscular lesions, the preponderating structural involvement is in the spinal muscles. Usually the whole region of the spine is affected, while the joints to which the lesioned muscles are attached move to a greater or lesser degree under active and passive spinal exercise. Such lesions, not frequently encountered, are difficult to overcome.

**So-Called Compensatory Lesions:**
These so-called lesions are secondary to chronic vertebral lesions, such as traumatic, reflexed, etc. In this condition, the vertebrae are so rotated that an apparent curve or swerve in the column results. Treatment applied directly to such a condition almost invariably fails to remove the ailment from which the patient suffers. Moreover, the articular surfaces are not firmly adherent, if at all. So it seems illogical to term such a condition a lesion, even though the articular surfaces throughout the compensatory area rest in a slightly mal-approximated position. If, on the other hand, joint fixation is present, a true lesion exists; and the sooner it is removed the better for the patient. This latter condition, if secondary to a lesion elsewhere in the spine, but not reflexed, is clearly an idiopathic lesion resulting from a displacement of the center of gravity.

**Unclassifiable Lesions:** These lesions are accompaniments of unhealthy old age. They often involve the whole spine, although the cervical region is the most common point of attack. Extreme muscular rigidity, low grade tissue deposits and complete articular immobility, are the distinguishing features. Such spinal conditions often refuse to yield to treatment. The author has observed this form of spinal affection in middle aged men; but it was always associated with premature old age or some lethal malady.

**Prognosis:**
As already stated, chronic articular idiopathic lesions yield to treatment more quickly than any other type. Although there is extensive spinal involvement, and the patients oftimes appear to be in a precarious condition, removal of the lesions is easily effected and restoration to health quickly follows.

(To be continued.)

**Note.—**In the next issue of “The Philadelphia Journal of Osteopathy” the treatment of articular idiopathic lesions will be discussed. Also case reports from practitioners in the field will be presented to strengthen the practical side of the discussion.—Editor.

The McClure Publications have notified the A. O. A. Press Bureau in reply to its objection that they will accept no further advertisements from the National School of Chiropractic. The McClure publications include: McClure's Magazine, The Ladies' World, Harper's Weekly.
Health undoubtedly depends to a large extent upon intestinal activity. Alvine evacuations are imperative daily. Very few people have been fortunate enough to escape intestinal obstipation at some period of their lives. Sooner or later inattention to the calls of nature, and the neglect to regularly attend to this important duty is instrumental in producing the most detrimental results. Mental derangement will accompany the physical discomfort, when this important function is not properly and regularly performed.

Costiveness is a functional hypo-activity of the large intestine, which serves as a temporary reservoir for the excrementitious residue of the alimentary matter and for the effete materials excreted by the intestinal mucosa.

Habitual intestinal inertia is productive of many derangements resulting from sympathy, irritation, or mechanical obstruction. If fecal matter is retained until it is decomposed, great injury follows since the vile fluid portion is absorbed, conveyed into the blood and corrupts it with its impurities. However, the resultant disorder is seldom attributed to the torpid condition of this intestine. It imposes greater tax upon the liver which is usually blamed for the trouble instead of the intestine itself. Occasionally the blood of the patient is so laden with these impurities that their odors can be detected in the breath of the subject.

In addition the continued distention of the large intestine with feces may gradually produce inflammation of the liver and abdominal dropsy. A dilated colon mechanically impedes the circulation of the blood in the abdominal viscera, causes congestion of the portal system and predisposes to chronic inflammation, or cirrhosis of the liver. The latter frequently gives rise to dropsical infiltration. Furthermore, the continued presence of excrement in the intestines tends to diminish their sensibility.

Frequently, young girls at the age of puberty, become imbued and possessed with the idea that infrequent bowel action is desirable at that particular time. They seem to think it an inelegant and repugnant practice and do not believe it to be a duty essential to health. Consequently incipient hepatic and pulmonary diseases are aroused at this very susceptible time. The constipated condition of the bowels is productive of numerous cases of leukorrhea, uterine congestion, followed by uterine debility, menorrhagia, anteversion or retroversion of that organ. Many other disorders complicate and the inexperienced girl with her solicitous parents are at a loss as to where to look for remedial aid. They seek specialists or a private sanitorium, where flattering expectations of speedy recovery are aroused. At these institutions the uterine disorders are generally treated as a mere local condition while its true etiologic factors are overlooked.

Therefore, permanent relief is not obtained. Having spent nearly all, or most of her funds, the patient returns home utterly disheartened and disgusted. After such failures, numerous patients of this type frequently consult an osteopath and by persistently following his directions and taking treatment regularly, are restored to health.
amid the comforts of their homes and amongst their friends at a comparatively trifling expense. It seems that heredity assumes an important role in the etiology of constipation. In some patients the condition had its inception during early childhood and varied little until bleeding tumors developed.

In addition, I think a sense of false modesty must be included as a cause of constipation in many instances. In the rural districts an out-house that is damp and uncomfortable and is situated at a distance from the dwelling, or the access is too public, there is much reluctance to visit it at the proper time. Then again, it seems that some are too indolent to attend to this duty. The reverse is the case where the individual is too energetic and will not spare the time until after some self-imposed task or pressing engagement.

An inactive, sedentary life also predisposes towards constipation. Exercise increases the body functions and regulates the activity of the bowels. Literary pursuits determine the blood to the brain thus drawing it from the extremities, the temperature becomes subnormal and congestion of the bowels invariably results. Girls attending boarding schools, or those whose occupations require them to sit and toil do not get sufficient exercise for the muscles of their bodies and are frequently troubled with obstinate constipation. This derangement is often due to the food prepared with the modern modes of cookery. People consume entirely too much bolted wheat flour. The branny portion of the kernel of wheat contains more than five times the amount of phosphate of lime contained in fine bolted flour. The daily users of boiled cracked wheat are very seldom troubled with constipation.

Where it is of a transient temporary type, arising in the course of acute diseases or accidental circumstances, the treatment is simple. As far as possible when the condition becomes chronic its cause should be ascertained and obviated.

I will divide the treatment into—
1. Prophylactic.
2. Osteopathic.
3. Surgical.

1. Prophylaxis.—The habit of daily, systematic evacuations at an appointed time favors regular intestinal activity. Calisthenics, such as horseback riding and prescribed gymnastics develop the abdominal muscles and are valuable in the treatment of this condition. Instruct your patients to instantly attend to the calls of nature and to thoroughly complete each evacuation. Dietetic measures are also efficacious. The food should consist of easily digested fats and oils. Freshly cooked green vegetables are also permissible. Prescribe the use of salted, smoked, potted or preserved fish, or meats, beets, puddings of rice, or sago, pastry, milk, tea, bananas, new bread, pickles, hard boiled eggs, fried foods, pork, veal, liver, red or sour wines.

2. Osteopathic.—Osseous, ligamentous and muscular lesions figure prominently in the etiology of this condition. Verterbral lesions of the seventh dorsal produce intestinal hypoactivity by diminishing the usual degree of enteric lubrication by lessening the biliary and mucous secretions. Lesions of the ninth dorsal by inhibiting peristalsis and those of the eleventh dorsal by altering the intestinal secretions, sensations and blood supply, which decreases the actions of the bowels and permits impactions. Lesions of the second lumbar vertebrae directly affect the center of defecation, interfering with the sensory, afferent impulses to it and the
efferent motor impulses emanating therefrom and the nutrition of the center itself. Adjust all vertebral subluxations and relax the muscles from the fifth dorsal to the fifth lumbar. Gently knead the bowels along the course of the colon in the reverse direction of peristalsis. The coccyx will frequently be found in malposition and should be replaced. A rectal dilator may be used in cases where the sphincter ani obstinately resists dilatation. Raise the lower ribs on both sides and note whether there is any approximation or depression of them. Stimulate liver by petrissage and vibration. Insist that your patient consumes large quantities of water daily and that a glass of cold water be taken before breakfast and just before retiring each night.

Buttermilk, Graham or rye-bread, butter, fruit, prunes, grapes and honey are to be recommended. Of the saline and mineral waters, I would suggest Pullna, Friedrickschell, Carlsbad, Pluto and Hunyadi Janos. Children will find Pullna or Friedrickschell in milk especially active and suitable.

Apply Faradic current to the abdominal walls. Connect the negative pole of the battery with the wet sponge electrode and place on the anus. Then pass the positive electrode over the liver, spleen, stomach and intestines using a secondary current for fifteen to twenty minutes. Cold sponging and baths are useful hydro-therapeutic adjuncts.

The use of warm water enema, I always strongly interdict as I believe they produce intestinal torpor. Injections of soap suds and salt to a pint of cold water are preferable. I also use pure glycerine alone, or in combination with sweet oil and inject slowly with a piston syringe. Flushing the colon with the use of a rectal tube is necessary in some cases.

3. Surgical.—When the constipation is due to hernia, congenital closure of intestines, tumor and cicatricial strictures, intestinal obstruction and constriction, volumus, intussusception and from external compression, such as arises from uterine, omental and ovarian cysts or tumors, pelvic abscesses, etc., surgical treatment is indicated. Some surgeons anastomose the small intestines with the sigmoid flexure or rectum, but I think that procedure is too radical for consideration, unless perhaps in those cases where the costiveness is extreme and the resulting symptoms intolerable. I would not recommend such an extraordinary surgical operation until osteopathic treatment had been taken and proven positively ineffectual.

Hagerstown, Maryland,
Feb. 26, 1914.

Editors,
Journal P. C. I. O.,

Gentlemen:
I have to report an item of possible interest to a number of the osteopathic profession, and is I believe a legitimate form of “local” for publication in our journals, to wit:—

On 10th inst., Dr. J. S. Johnson, B.S.D.O., Graduate of A. S. O., 1912, purchased the office equipment and good will of my practice, established here in 1901; I to remain in association with Dr. Johnson, for introducing to patients, until April 1st, next.

After resting from professional work for several months, I intend to locate permanently in Charlestown, W. Va., the former home of my wife, and which town, during the first six years of my Maryland practicing, I visited regularly securing a generous number of West Virginia patients. I hold the first certificate of osteopathic registry, issued by the State of West Virginia.

Fraternally yours,
A. M. Smith, D.O.
PROSPECTIVE students contemplating entering the Philadelphia College of Osteopathy in September should communicate at the earliest opportunity with Dr. Arthur M. Flack, the Dean of the College, giving detailed particulars of their preliminary education. In order to enter, it is necessary to have a preliminary education consisting of a standard four year high school course or its equivalent, including one year of Physics or Chemistry and of Biology. If any deficiency exists an early adjustment of the matter should be undertaken so that entrance may be had at the opening of college. The next term begins September 24, 1914.

Osteopathy for the Infections of Childhood
(Measles, Chicken-Pox and Scarlet Fever.)

BY EDWARD J. DREW, D.O.

It is perhaps the experience of every osteopath to be asked “What can you do for fever,” or “What would you do in the case of an infectious disease?” My answer is always that we can do as much as medical treatment in any case, and in the majority of cases we have the satisfaction of leaving our little patient improved, that is, feeling better for our visit.

A great deal of patience is required in dealing with this class of patients. Children, as a rule, stand pain and discomfort less readily than adults, but show, to the trained eye, abnormal conditions more readily than do our older patients. It is harder to detect the fine points which are essential in diagnosis, and we must make a rigid examination, because children cannot tell you their troubles.

When called to see a child it is well to ask, in families who have children attending school, whether the school has been closed for any contagious disease, within a recent period, or if the child has been exposed to infection from other sources. The period of incubation varies in all infections but from a knowledge of the average, in the more common ones, that is, measles, scarlet fever, chicken pox, you can gain some idea of the severity of the infection you are dealing with; this, of course, has its limitations. The severity of an infection is not always indicated by the severity of the onset. Varicella (chicken-pox) usually starts with moderate fever which rarely becomes high. On the other hand, scarlet fever usually starts with a high fever (103 to 105) but occasionally we see a case starting with a mild or slight fever.

It is a good rule to take the temperature of the child and record it upon the first visit; also the number of respirations, note the pulse—whether full and strong, weak, or steady and pulse rate. A very good rule is to examine the mouth and throat—note whether the tonsils are swollen and have an exudate and note whether the buccal mucous

(Continued on page 10.)
Members of the Faculty of the Philadelphia College of Osteopathy, who are specialists in their subjects continue to give their services to the Osteopathic Societies meeting in nearby States.

On October 18th, Dr. Arthur M. Flack, Dean of the College, and Professor of Pathology, delivered a very able address before the Maryland Osteopathic Association, meeting in Baltimore, on the subject of "Pathology in Practice." Dr. Flack is also scheduled to address the Western Pennsylvania Osteopathic Association which meets Saturday, November 15th, at the Hotel Pett, Pittsburgh, Pa., his subject being "Tubercular Peritonitis." Dr. Wm. S. Nicholl, Professor of Ophthalmology, addressed the New Jersey Osteopathic Society at Newark, on the evening of November 8th, on "The Osteopathic Treatment of Iritis and Glaucoma."

Dr. Flack and Dr. Nicholl are both well qualified to do justice to these subjects. Their years of teaching and practical work as members of the Faculty, and the special and research work which they have done in their respective specialties have put them in the front ranks of the Osteopathic teaching profession.

At a meeting of the General Committee on Arrangements for the coming National Osteopathic Convention, held Tuesday evening, October 21st, in the office of Dr. Nettie C. Turner, Land Title Building, Philadelphia, Pa., the following officers and chairmen of committees were announced—

Dr. Wm. S. Nicholl, chairman of the General Committee on Arrangements; secretary, Dr. W. Armstrong Graves; treasurer, Dr. Nettie C. Turner; chairmen of the committees as follows: Clinics—Dr. Chas. J. Muttart; Entertainment—Dr. Marie E. Magill; Finance—Dr. Nettie C. Turner; Exhibits—Dr. Irving Whalley; Halls—Dr. A. D. Campbell; Information—Dr. Robt. J. Storey; Press and Publicity—Dr. A. M. Flack; Registration—Dr. E. Harry Leonard; Re-unions—Dr. Jane Scott; Transportation—Dr. O. J. Snyder; Accommodations—Dr. Earle F. Willard.

Plans for the collection of the necessary funds have been formulated by the Finance Committee. The report of this committee at the next meeting of the General Committee will show, it is believed, a generous response on the part of the profession.

Next Class matriculates September 24, 1914. Please mention this Journal when writing for Catalogue.

(Continued from page 9.)
ing with you a sterilizable cap and gown, or a suit which can be sterilized.

**Treatment.**—The treatment of a contagious disease is divided into Preventive (that is, to guard against carrying infection to others), and Curative.

**Preventive Treatment.**—Isolation of the patient is essential from the beginning, and whenever possible the nurse should stay in the room with the child and all the dishes and clothing used by her or the child, should be washed in the same room, or, a better plan, in an adjoining room.

The physician, upon entering the house should take off his coat, roll up his shirt sleeves and put on his cap and gown. The gown should be long enough to cover the shoes, and the cap should entirely cover the hair. The parlor downstairs is a good room to dress in, providing the patient is upstairs. In case of an apartment, a third room to get dressed in is an ideal arrangement. Some hygienists advocate the use of a gauze mask to cover the mouth and nose and claim that this prevents, to an extent the germs from getting into the air passages. Upon leaving the patient's room, the physician should remove the cap and gown and should place them immediately in a bucket containing a bichloride of mercury solution 1-2000, or a carbolic acid solution 1-20. He should then wash the face and hands in the bath room, and should put on his street clothes in the first room (the parlor). The gown is left in the solution for from one to two hours; it is then dried by someone in the house and is placed in the room which the physician enters first.

**Curative Treatment.**—The osteopathic treatment should be directed, first, to the kidneys, liver and bowels through their spinal centers, and in the case of the liver and bowels, directly to these organs. A high rectal enema should be given as soon as the case is seen. I always prefer to give it myself, using a colon tube. In the case of a small child one quart of normal saline solution can be injected, increasing the amount of solution according to the size and age of the child. It is often the case that younger children go to sleep soon after a treatment. A thorough relaxation of all tissues should be given to the sub-occipital region to increase the amount of arterial blood going to the brain, and in this way, to give the heat centers, blood that is not loaded with toxins, which is always the case when the brain gets congested blood. The idea is, to get the blood as quickly as possible from the lungs to the brain. Treatment to the anterior cervical structures will decrease the congestion in the sinuses of the skull and this helps the arterial blood to circulate more freely. This is accomplished through the jugulars and the internal maxillary veins which are the main drainage from the head.

The frequency of treatment depends upon the severity of the case. A child running a temperature of over 103 should be seen twice a day until the temperature is below 102, and then once a day until the temperature is normal. In the interval of treatment, when the temperature is high, a warm bath from 90 to 100 F. should be given. Cold sponges or alcohol baths are only indicated when the temperature is over 104. They should then be given about every four hours, using fifty per cent alcohol in water heated to about 90 F. The treatment as here outlined applies to these cases in general. The special treatment of the individual cases needs further explanation.

(To be continued.)

Next Class matriculates September 24, 1914. Please mention this Journal When writing for Catalogue.
SENIOR NOTES.

The college days for our class are nearing an end. After having spent four years in college, it is now our duty to go out and administer to the sick. Through the able assistance of our teachers, we feel confident of upholding the standard they have set, and we wish to take this means of thanking them for all their kindness and help, not only in the classroom but outside. It is with a feeling of regret that we are leaving the scenes of many happy days, but this in a way, is offset by the anticipation of the wonderful things we expect to accomplish while “in the field.” We also wish to thank Dr. McEwen for her assistance in the hospital.

JUNIOR CLASS NOTES.

The Junior Class certainly can give the college surprises, they have started “Quiz Classes” conducted by some member of the class and are getting in some very good work incidentally they are so busy that they have no time for “revolution” and other Freshmen-like things so that there is a ghostly silence pervading the campus and halls.

We are thinking seriously of getting a branch telephone, with a nice cute booth, attached up in the Junior room for Vick’s private use; he will surely get hypertraphy of the heart from going up and down the stairs if we don’t help him.

Poor Lorraine was ill when we had our great spread and was not able to be with us in body but she was there in spirit, as was proved when she paid up her share. They say the Dutch aren’t sports, too.

The Junior Class assembled on February 27th at Mayer’s, at eight P. M., for their annual banquet and it was voted the greatest success gastronomically and convivially of our whole history. First, the menu was a very excellent one, the music was pleasing and the souvenirs and decorations appropriate and pleasing to the eye. But the sum and substance of the whole success was the spirit of brotherhood, of mirth and jollity and of class union which prevailed. We had some toasts, of course (they go with every banduet) but they did not predominate the evening, as the members were all sparkling with wit and humor and anxious to get it out of their systems, therefore, they did not need to be called upon, in fact, we tried to keep some of the most talkative ones down. After we were through eating we had music and some of the latest tango steps were executed by the members so that in all we voted it “great” and thank the Banquet Committee for their efforts.

Dr. Dufur is attending another physician’s practice, who was just operated upon, so he will be busy for two or three weeks at least. “Some practice.” Dr. Bailey is taking the class in Symptomatology during Dr. Dufur’s absence.

The Junior boys are all working hard so that they can have some extra time for baseball and track. We have the “Class” in Athletics as well as in other school activities.

Tommaso Creatore, ’15.
PERSONALS.

The one wish of every senior—"I wish the State-boards were over."

If we (editors) were in your place, Wiggie, we would announce it. Come on, it's near the end and we would like to be sure.

While we are on this subject, why not let the above apply also to Drs. Thorburn and Staver?

Dr. Trichler is certainly talented. She is fine at tailoring—I know.

Who's the gentleman that just went out? Oh, that's Eldon.

When anyone is in trouble (that is, serious trouble) especially in the laboratory, apply to Mrs. Leopold for advice. Acid is an awful thing to remove from one's clothes, isn't it, Mrs. Leopold?

When it comes to throwing water, Ted Beale is certainly "on the job." She can wet you all over with one beaker full, and put the fire out, too.

McHerron seems to enjoy "looking 'em over" on Broad Street on Sunday afternoons. We wish you luck, Doc.

We would like to know what takes Mulford to Atlantic City so often. Business or—Doc. Cardamone, you can't get away with it. We're wise, long ago.

The members of the class are certainly glad to see Dr. Maleski back again after having a serious illness.

Respectfully submitted,
John J. Stearne,
Geo. A. Gereke,
Editors.

P. S.—Since these notes have gone to press, it is necessary to make a correction—WIGGINS HAS ANNOUNCED IT.

ATHLETIC NOTES—BASEBALL.

The schedule for baseball is nearly completed. The management has secured games with Drexel, Temple, Pharmacy, Arts and Textile and Wenonah and with a few more games the team will have its hands full. We have very good prospects indeed, and we are now negotiating to rent a field to practice on so that everything is cheery for good prognosis. The reports of the candidates have been slow in coming in but the snow on the ground and the wintry gales can account for that and we expect a goodly number to come out as soon as old Sol allows. You want to all come out as there is a possibility (don't whisper it to anyone) of the team getting sweaters at the end of the season. Watch the rush.

Tommaso Creatore, '15.

CLASS OF 1916 NOTES.

Now that mid-years have passed we are all resting much easier. For some reason exams are not at all popular with our class.

Dr. Ira Drew is conducting some very interesting classes in Regional Anatomy, and with the aid of the stereopticon and unusually good cuts the work is made much clearer.

Dr. Drew deserves a great deal of credit for working up this system, as well as Mr. Eunson, his able assistant.

Dr. Fritsche has started on laboratory work in Urinalysis, and all seem to be getting a good deal out of this important branch.

(See Paper 2.)

"Plague of My Art."

The Class of 1916 presents the great melodrama:

"Hunting the Microbe."

CAST.

Detective—Earl Miller.
"Trusty"—Louis Eunson.
Grace Shinn—Microscopic Specialist.
Gertrude Burgess—Champion at Argumentation.
Act I—Scene I.

Bacteriology Laboratory.

Miller.—I have shadowed Klebs Loffler, better known as "Diphtheria Bill" and now have hom safely caged in yon incubator.

Eunson.—(hastily) Have a care Earl, as Klebs Loffler is exceeding clever and may vanish at a moment's notice.

Miller.—I have watched the incubator, even as a cat watches a mouse, and with my trusty cleaner on my hip, I fear naught.

Shinn.—Oh! Earl! Use a microscope! You never can scotch the dastardly Klebs Loffler without it.

Miller.—Hush, Grace; you will betray my presence and all will be lost. Hide yourself behind your garbage can and await developments.

Burgess.—I have the solution. Use a Wm. J. Burns' dictagraph and any statement he may issue will be used against him.

Miller.—All very clever Gertrude, but this Klebs Loffler needs to be handled with a platinum wire and not a dictagraph.

(Much action at this point and argument prevails, Miller vs. Burgess. The bets have been laid as to the outcome and the odds are on Burgess.)

Eunson.—(throwing open the incubator) Alas! All is lost. During the heat of the argument Klebs Loffler has been scorched and died as a result of passing his "thermal death point."

Miller.—(throwing out his chest) I have the mystery solved. The heat of the argument raised the thermometer several degrees and therefore the death of Klebs Loffler. Very simple when you know my methods.

CURTAIN.

W. B. Underwood, Editor.

Professor of the dance, Tait, has been very patient with his class and we understand Evans, one of his pupils, is now giving lessons and exhibitions to the students out at the University of Pennsylvania.

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S. R. Clarke will hold class hereafter every Tuesday afternoon, explaining the presence, location, function, blood and nerve supply and action of fibrinogen.

Dr. Hoopes.—Smith, what is work? Smith.—I don't know; what is it? Answer in Zoology.—The Mediterranean is the play-ground for little sponges.

Wake up, Sophs, Friday evening, January 30th, the Freshmen held their banquet after attending a show. Although there was much talk about the Sophs interfering, this was not apparent, because we put one over on the Sophs.

We were very glad to hear Dr. Wiggins call for candidates for the baseball team. About two days later we witnessed a warming up of the Freshman battery, Patterson and Corliss, in the Freshman hall.

At the beginning of the new semester, we Freshmen were very glad to welcome S. R. Clarke, formerly a well known and highly esteemed Rochester man as a member of our class. We look forward to his doing things, because he has done "some" heretofore.

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