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Kappa Psi Medical Fraternity



U. S. P. H. S.

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APRIL, 1919

WHOLE No. 66

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COMPLETE WAR SERVICE NUMBER POSTPONED

At the suggestion of several chapters and many individuals, the staff decided to postpone this number from the January issue (*as announced in November*) to the July issue in order to give sufficient time for complete data to be compiled by *all* chapters, many of which are now in the midst of reorganization necessitated by the S. A. T. C. interference of last fall.

Your Help Needed

Therefore, EACH CHAPTER HISTORIAN will send *at once* the name of every member you know who is or was in the service and whose name does not appear, or appears incorrectly, on the Service Roll published in the July, 1918, issue.

Address all communications to

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The Mask

VOL. XVI, No. 2

APRIL, 1919

WHOLE No. 66

A MESSAGE FROM THE SURGEON GENERAL, U. S. P. H. S., TO THE K Ψ FRATERNITY

To the Members of K Ψ:

The war proved two things which I desire to bring in this conspicuous manner to your attention:

(1) The priceless value to the nation of its young manhood, especially its educated manhood.

(2) The ghastly and unsuspected toll taken from America's manhood by venereal disease.

Our army was the cleanest in the war, and its clean record had not a little to do with its morale and its fighting effectiveness. Yet General Gorgas stated that even if the commanding general could lay aside all question of morality, he would probably choose the eradication of venereal disease rather than the prevention of wounds.

The critical period which the nation now faces must depend even more upon the integrity of educated manhood, which American college fraternities hold as their ideal and of which they furnish such conspicuous examples.

I naturally turn to you, therefore, at this time in a definite appeal and request that every fraternity and every jurisdiction and member thereof go on record, not only as insisting upon compliance with the fraternity's own highest standards of physical integrity, but as actively though unobtrusively exerting influence in support of the Federal campaign against the venereal diseases.

Respectfully,

RUPERT BLUE,

Surgeon General.

A PLEA FOR A MORE INTELLIGENT INTEREST IN TUBERCULOSIS ON THE PART OF THE MEDICAL PROFESSION

BY F. H. McKEON, M.D., *Zeta '05,*

Surgeon, U. S. Public Health Service, Fort Stanton, N. M.

It may appear to many that a plea for a greater interest in tuberculosis at this time is a work of supererogation. It could be urged, and truthfully so, that more thought is being given to the tuberculosis problem, not only by physicians but by the laity, than ever before. The numerous municipal, state, and national associations for the prevention and cure of the disease and the sanatoria located in every state of the Union might well be adduced as evidences of wide spread interest. But while admitting these facts and having the greatest admiration for the work that has been done and is being done, the writer maintains that there is a need for a more intelligent interest in tuberculosis on the part of the



MAJOR F. H. McKEON, *Zeta '05,*
U. S. P. H. S.

medical profession. This conclusion has been reached after nearly four years' service at the sanatorium of the United States Public Health Service, during which time there has been ample opportunity not only to examine the work of his brother officers but to observe the activities of many physicians practicing in the Southwest.

Many tuberculosis workers, among them the best, are abandoning the clinical side, which includes not only the treatment of a tuberculous person but also the teaching him to take such intelligent care of himself that he will not be a menace to the non-infected, for the broader and more important field of work which has as its object the ultimate eradication of the disease. This is as it should be for if we are to rid the human race of this, the greatest scourge ever inflicted upon it, we must push our battle line forward, and not be content with merely holding our trenches and caring for our wounded as we have done in the past. That we have still much to learn concerning the means of

transmission of the disease and the manner in which immunity to it is gained, is conceded by all investigators. But little by little we are adding to our knowledge and although the time is very far distant when it will be said that tuberculosis is conquered, there can be no doubt that a time is surely coming when it will cease to exist as a manifest disease. It may be that the solution will be found in regular periodic physical examination of all persons by properly qualified physicians, thus detecting the disease in all cases in its very infancy, and having learned of its presence taking such steps as will insure not only the recovery of the threatened one but the protection of those about him. Or it may happen that a biologic product will be elaborated that will confer active immunity, especially to children, as is now done in smallpox and typhoid fever. Bushnell¹ suggests that the absolute isolation of all children from tuberculous adults, since practically all tuberculosis is contracted during childhood, will result in the ultimate disappearance of the disease as an entity. The tubercle bacillus, he avers, will always be with us but only as a benign immunizing agent. This plan, however, would have to be secondary to the periodic physical examination of all persons, urged by Smith², since it would be necessary to know the adults who would be dangerous to children. There are a large number of cases of open tuberculosis with symptoms so mild as to never attract the attention of the infected one or those about him. And if, as frequently happens, there is a sufficient amount of antibodies formed to heal the lesion before much tissue destruction occurs the "carrier" never knows that he had the disease. It is this type of case that is particularly dangerous to children. There are those who tell us that in time racial immunity will be established and the disease thus held in check. They point to the comparative infrequency of phthisis amongst the Jews, the oldest of civilized races, and to the hyper-susceptibility of the Indian, the youngest member of civilization, as proofs of the argument. And given sufficient time and isolation from all other peoples, a race might attain a high degree of relative immunity. But the length of time needed would be too great and the world is so constituted today that it is impossible to prevent intermingling of the less immune with the more immune races.

However, these speculations as to what the ultimate solution of the tuberculosis problem will be, interesting as they are, have only an indirect bearing on the task that confronts those who are fighting to prevent the spread of the disease in the present. And in the last analysis it is the general practitioner who can do the most along this line. It is he who first sees the patient when the latter is impelled to seek medical advice by reason of the vague symptoms, often not referred to the thorax, which should indicate to the physician the need of a careful and thorough examination of the lungs. Too often a patient complaining of indigestion, or malaise, or a slight cough, is given a prescription intended to control the symptom and told not to worry. The relief experienced from the digestant, cough mixture or tonic lulls

the patient into a feeling of security and allows the disease to continue its insidious attack. When the diagnosis is finally made, the case is too often found to be a far advanced one. Even then it is in rare instances that the physician has sufficient conception of the nature and extent of the lesion to properly advise his patient. The vague advice to "go West" is not sufficient. The one almost universal idea that certain climates have a specific action in healing tuberculosis lesions is being abandoned. And while it is not within the province of this paper to discuss the effect of climate in tuberculosis, I cannot refrain from the statement that the rôle it plays would seem to be a comparatively unimportant one.

In a recent article, Ford³ undertook a study of one thousand cases that had been admitted to the Gaylord Farm Sanatorium between October, 1907, and January, 1915, in order to see just what was being done by the family doctor in his efforts to diagnose pulmonary tuberculosis correctly. His article deals rather with the neglect of the physician to utilize the diagnostic means at his disposal than with correct diagnosis, but it is so near the point that I am trying to make that his summary is given herewith:

These consulted nineteen hundred and forty physicians of whom 1,085, or 55.1 per cent, made a physical examination only, and of this number, 151 did not deem it worth while to have the patient strip; 13, or .7 per cent took temperature only; 14, or .7 per cent, made a sputum examination only; 381, or 20 per cent, made a chest and sputum examination; 114, or 6 per cent, examined the chest, took temperature, but did not make a sputum examination; 3, or .02 per cent, took temperature and made a sputum examination, but no physical examination; 133, or 7 per cent, made a chest examination, took temperature, and examined sputum; 197, or 10.2 per cent, made no examination of any kind.

In other words, only seven per cent of 1,940 practicing physicians gave evidence of sufficient knowledge of clinical tuberculosis to realize that no one can arrive at an intelligent opinion as to the presence or absence of the disease without utilizing the stethoscope, the thermometer and the microscope. Of course, I am speaking now of the class of cases that have not advanced to the hopeless stage. It does not require much diagnostic acumen to pronounce the far advanced consumptive, with his emaciation, lagging gait, harassing cough, and copious expectoration, to be tuberculous. While it is not given to every one to have sufficient skill in percussion and auscultation to detect an early lesion, although I believe that the great majority of educated physicians can be taught to do so, all of us are or should be able to properly interpret temperature findings; and what is more important should have a lively sense of the large part that the thermometer plays, when correctly used, in the diagnosis of tuberculosis. Very frequently an accurate temperature record kept for a period of three weeks to a month will enable one to diagnosticate the disease even before the most expert can find physical signs.

Another mistake pointed out by Ford is the failure of the practitioner to realize that the spitting up of blood usually means tuberculosis. Smith⁴ found that out of a total of 1,210 cases of pulmonary tuberculosis admitted to the United States Marine Hospital (now Public

Health) Sanatorium, at Fort Stanton, New Mexico, 354, or approximately 21 per cent, gave a history of having had one or more hemorrhages before arrival. The relative frequency of hemorrhage before admission, since I have been stationed at the sanatorium, is about the same as it was then. In taking anamneses at the time of the first examination, I have been particularly struck with the number of men who stated that they spat blood one, two, or more years previous and had sought medical advice only to be told that the symptom meant nothing more than "throat trouble," or something equally vague, and need cause no alarm. Very rarely was an examination of the chest made. Now, as Ford well says, there may be some excuse for a man who carefully examines his case but makes a wrong diagnosis, but there is absolutely no excuse for the man who takes neither time nor trouble to go over his patient.

Passing from the men who fail to utilize the means at their disposal to make a diagnosis to those who do, what do we find? Perhaps not such a deplorable state of affairs, since, as has already been said, there is some excuse for the man who attempts to make a correct diagnosis and fails, but certainly a most lamentable one. The admissions to Fort Stanton from July 1, 1913, to January 31, 1915 (this period is chosen because of the writer's personal knowledge of conditions during the time) numbered 414. Of these, 376 were transferred from various United States Marine Hospitals, the remaining 38 being readmissions who came back by authority of the Surgeon General without having applied at a marine hospital for relief. When a diagnosis of tuberculosis is made in a patient at a marine hospital, the officer in charge requests authority from Washington to transfer the patient to Fort Stanton if in his judgment the man is able to travel and is a suitable case for sanatorium treatment. When the request is made a copy of the patient's clinical record, including the physical findings, is sent with it to Washington. The record is subsequently sent to Fort Stanton. In this way the officers at the sanatorium are enabled to compare their findings with those of the transferring station. Original examinations at Fort Stanton were made at the time this was written, by the commanding officer, Surgeon F. C. Smith, U. S. P. H. S., assisted by the writer. Dr. Smith is a recognized authority on pulmonary tuberculosis whose judgment as to the nature and extent of a lung lesion would be accepted as correct by practically all phthisiologists in this country. Hence, I feel justified in making the findings at Fort Stanton the standard so far as the United States Public Health Service is concerned.

Out of the 376 admissions referred to above, less than 2 per cent had been correctly diagnosed at the transferring station as to the nature and extent of the lesion. I have reason to believe that similar conclusions would be drawn if inspections were made of the records of the other two government sanatoria. In considering these statements, it is to be borne in mind that the transferring officers are for the most part commissioned officers of a government medical corps; that they are

commissioned only after passing a rigid examination, the standard of which is considerably higher than that maintained by any state examining board; that in order to be considered for commissions they must be graduates of high-grade medical schools and have presented satisfactory evidence of liberal pre-medical education; and that their service experience has afforded them opportunities to become skillful clinicians or sanitarians. If these highly trained men are not competent to properly elicit and to correctly interpret the physical signs of phthisis, what can be expected of the ordinary practitioner? The latter is frequently a man of only ordinary medical training whose opportunities to add to his store of knowledge are limited. If he does find time to visit a medical center he is attracted to the clinics of the skillful surgeon or the brilliant internist rather than to the clinic where correct methods of early diagnosis in tuberculosis are taught. His experience leads him to believe that a person with the disease is doomed and, since he rarely makes a diagnosis until the process is far advanced, he is correct in his belief. He cannot be interested in a disease that apparently offers no opportunity for cure.

It is self-evident that one cannot be interested in a subject unless he has knowledge of it; and the great majority of the medical profession has only a vague general knowledge of tuberculosis. The blame lies not with the practicing physician, however, but with his teachers. The general early diagnosis of phthisis will not be possible until every medical school gives the subject the prominence it deserves. How this may be done will be discussed later. Much may be learned, however, from a study of the numerous excellent text-books on the subject and it would seem that every physician who may be called upon to diagnose and advise in a case of pulmonary tuberculosis should realize the importance of familiarizing himself with at least one of these works. After examining several hundred case histories written by men who transfer patients to the sanatorium at which I am serving, I cannot escape the conviction that the average physician is ill-advised as to the fundamentals of the pathologic processes of phthisis. It cannot be said of this phase of the subject as was said of the diagnosis that due importance is not given it in the schools. Practically all graduates in medicine have received adequate instruction in the pathologic anatomy of tuberculosis, but very few of them seem to retain any considerable portion of it. And since no intelligent conception of the meaning of physical findings can be had without a knowledge of the underlying pathology, a return to the text-books would seem to be indicated. And it should not only be known that there are stages of infiltration, of consolidation, of tissue destruction and of connective tissue proliferation, but that these processes may be of varying ages and degrees of activity and when properly interpreted strongly influence the prognosis and treatment.

Résumé:

What shall we do for the far advanced consumptive? Certainly we should put him in an environment that will effect an arrestment of his

disease if that be possible; prolong his life and earning capacity if we may; but in all cases make him as comfortable as may be and keep him from being a menace to others, especially to children. Sanatorium or hospital treatment will accomplish these desiderata in most cases and the nearer the sanatorium is to the patient's home the better it will be for all concerned. The patient without complete involvement of both lungs or serious complications, a reasonable degree of robustness, and only moderate clinical symptoms, may with profit be transferred to a different climate if he be a person of sufficient means or a government beneficiary. But to send a patient with nearly complete involvement of both lungs, marked emaciation, daily fever, rapid pulse, distressing cough, and copious expectoration, several thousand miles to a higher altitude is not only a waste of time and money but is criminal cruelty. Segregation of such cases is undoubtedly desirable, but it need not necessarily be done in an institution exclusively for the tuberculous. This statement holds good for the fibroid case as well. In this type, dyspnoea is always severe and since, as has already been stated, the life of a fibroid patient may be prolonged for a considerable number of years, it is of the first importance that he be where the act of breathing will be easiest for him. In other words, he should be at or near the sea level. Men above the age of fifty-five years with clicking rales in their chests and tubercle bacilli in their sputa should not be sent to a distant sanatorium.

Most of the complications can be treated equally successfully anywhere and some of them should be kept away from high altitudes. As has been stated, syphilis frequently accompanies tuberculosis and a Wassermann test should be made in all cases of phthisis where there is reason to suspect a luetic taint. Treatment with neosalvarsan followed by a course of mercury, and in selected cases potassium iodid, will often result in a marked alleviation of all symptoms.

It is not intended that the above should be considered other than as the barest outline of the symptoms and management of tuberculosis. On such a vast subject it would be impossible in a paper of this length to do more than stimulate thought. Much of what has been said is elemental and all has been better said many times before. Volumes have been written upon the importance of early diagnosis in tuberculosis, but since it is evident that only a small proportion of general practitioners have been reached, or at any rate impressed, by the voluminous literature, we must keep on iterating and reiterating that early diagnosis means cure and probably the eventual eradication of the disease.

The ability to detect early lesions is important to those of us who make examinations for enlistment for another reason: namely, the keeping down of the number of non-effectives and of additions to the pension rolls. A large percentage of enlisted men who break down with tuberculosis during their first two years of service probably had a demonstrable lesion, active or inactive, at the time of enlistment. The

same statement might truthfully be made of those persons who became manifestly tuberculous within two years of the time that they have been examined and passed for life insurance.

Reference was made previously to the need of more thorough instruction in the diagnosis, especially early diagnosis, of tuberculosis in the medical schools. When it is recalled that even now after years of hard and persistent fighting against it, the disease kills more than 140,000 persons annually in the United States alone and still stands first on the list of mortality tables it would seem that no such need should exist.* However, it is a fact that comparatively few American schools are properly equipped to teach phthisio-diagnosis and therapy. This omission in the medical curriculum should be remedied by requiring every "acceptable" medical school to have a clinical chair of medical tuberculosis. The chairs should of course be filled by men well qualified to teach the subject.

As has been indicated earlier in the article, the graduate in medicine can learn a great deal about the subject by frequently consulting the books that have been written on it. He should of course avail himself of post-graduate instruction whenever that is possible. He may never become a clinical expert in the diagnosis of tuberculosis, but he can learn to recognize the danger signals of the disease and refer his patients to a specialist before irreparable harm is done. Government medical officers should, upon being commissioned, be sent to the sanatoria of their respective Services for a course of instruction. When they have all been taught to recognize the early manifestation of tuberculosis and what class of cases are suitable for sanatorium treatment, the government will be saved a considerable sum of money annually.

In Conclusion, let it be said that the eradication of tuberculosis is peculiarly a problem of the physician. Social workers and philanthropic laymen can do much by improving social conditions and alleviating poverty, but the disease will never cease to exist until the entire medical profession has an intelligent grasp of the whole nature of tuberculosis and a keen appreciation of the importance of early diagnosis.

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*Since this statement was written, tuberculosis has fallen to second place on the list of mortality tables. (The author.)

PULMONARY SYPHILIS

BY M. FORD MORRIS, JR., M.D., *Rho*, Atlanta, Ga.

Syphilis is an old disease—so old, in fact, that “the mind of man runneth not to the contrary.” There is no good reason to disprove the supposition that lues venerea made its advent into this world not so long after Madame Eve partook of the forbidden fruit. Anyway, as early as two centuries B. C., a Chinese named King described the symptoms of syphilis. In the Bible, the references to the “emerods in the secret parts,” the unclean man with a “running issue of the flesh,” and to the “itch whereof thou canst not be healed” are very suggestive of this malady. Syphilis may have been present when the daughters of Moab vexed the Israelites with their wiles; and surely it had a most excellent opportunity to become a skeleton in the closet of every member of the various so-called religious cults of Rome, Assyria, and Asia Minor, whose doctrine taught and encouraged the wildest license and whose “holy” meetings were nothing more than sexual debauches. At the end of the fifteenth century, lues became pandemic soon after the syphilitic soldiers of Charles VIII reached Naples. Then this became so prevalent in Europe that Astruc said that everyone, from the Roman Pope to the lowest scullion in Christendom, was infected with syphilis. Ever since, the pox has travelled and has left its mark upon some door in almost every community.

Although the pale spirochete is present within the bodies of an appalling percentage of the earth's human inhabitants and although no organ or tissue within the human body, excepting possibly the prostate, is immune to the action of the *spirochæta pallida*, the lung suffers very infrequently. In some 2,800 autopsies at the Johns Hopkins Hospital, reviewed by Osler, there were but twelve cases of syphilis of the lungs. In 1898, there were but twelve specimens of this condition in the London museums. Even though this condition is comparatively rare, it is probably recognized more frequently now than it was formerly.

Depending upon either the prenatal or post-natal beginning of the syphilitic process, pulmonary lues is usually considered from the hereditary and the acquired aspects.

Inherited syphilis of the lungs is of two kinds: circumscribed and diffuse, the former being known as “gumma” and the latter as “pneumonia.” Hereditary pulmonary gummata are rare and differ in no way from the acquired form. The diffuse form is known either as “white pneumonia” or “interstitial pneumonia,”—but these two lesions usually are combined. Virchow described a diffuse change, in the lungs of still-born children or those who lived only a few hours. To this condition he applied the name “white pneumonia.” Lorain and Robin referred to it as *épithéliome* of the lung. In white pneumonia, the lung is much larger than it is normally, and its surface often shows the impressions of the ribs; part or all of a lobe is usually affected, but

even both lungs may be consolidated. The lung is usually of a white or greyish-white color, is heavy, dry, and, in still-born children, the affected part is devoid of blood and air. The alveoli are enlarged and filled with masses of cells, and the alveolar walls are thickened. The small bronchi are also filled with these cells which are usually undergoing fatty degeneration. As a result of capillary pressure, the blood-supply to the lung areas affected is greatly diminished in the cases that have lived a short time. Characteristic signs of congenital syphilis elsewhere are usually present, and the baby is usually born before full term.

Interstitial pneumonia often is associated with pronounced prenatal luetic lesions elsewhere. The life of a child with this condition is not prolonged. The most characteristic features of interstitial pneumonia are a small-celled infiltration of the interalveolar connective-tissue and a marked increase of the interlobular connective tissue. In some cases, the interalveolar strands enclose a network of dilated and tortuous capillaries. There is an increase of connective-tissue around the vessels and bronchi, and the tunica intima of the small arteries is also thickened.

Hocksinger summarizes the morbid processes affecting the lungs of syphilitic children as follows: (1) A round-celled infiltration and proliferation of the interlobular and interalveolar connective-tissue, originating in the cellular tissue around the bronchi, and leading to marked thickening of the lung; and (2) an isolated perivascular cell proliferation, which begins around the small arteries, and is accompanied by changes in the tunica intima.

In *acquired syphilis*, the chief pulmonary lesions are (1) gummata, (2) broncho-pneumonia, (3) fibroid induration or chronic interstitial pneumonia, and (4) a progressive destructive disease—the so-called “syphilitic phthisis.”

Gummata in the lungs are similar to gummata elsewhere. They range in size from that of a small pea to that of a hen's egg; and occur in all parts of the lung, but most frequently within the substance of the lung near the hilus. Gummata of the lung may caseate, but usually tend toward the formation of cicatricial tissue which causes a shrinkage of the surrounding lung substance as well as a dimpling of the lung surface and the adherent pleura. Fowler describes two of the specimens in the Museum of Guy's Hospital as follows:

“No. 255.—The lower lobe from the left lung of a man, aged twenty-seven, who died from erysipelas of the larynx. The specimen shows at its hinder part a large yellowish mass partially separated from the surrounding tissue. Smaller nodules are seen in the adjacent lung. The pleura over the gumma is much thickened. Histologically, the nodule consists of fibrous tissue which stains with difficulty. There were many gummata in the liver. With the exception of the above lesions and some bronchitis, the lungs were healthy. Suppurating buboes and a chancre on the penis were present.”

"No. 256.—A portion of lung showing scattered through it several small masses of irregular shape, yellowish in color, and firm on section. The masses are easily separable from the surrounding lung, which is healthy. Histologically, the nodules show a central area of caseous material surrounded by a narrow zone of fibrous tissue in which are many small round cells. The liver contained a single gumma, and, was in a condition of diffuse syphilitic hepatitis. There were several small gummata in the testes. From a man, aged thirty-nine, who had suffered from cough and dyspnoea for six months and who was admitted for hepatic ascites and slight jaundice."

(2) There is much doubt concerning the existence of a syphilitic broncho-pneumonia. Délèpine and Sisley recorded a most remarkable case in which an enormous gumma of the right lobe of the liver, measuring $5\frac{1}{2}$ by $4\frac{1}{2}$ inches in extent, and adherent to the diaphragm, pushed up and extended through the diaphragm, and, involved the lower lobe of the lung. In addition to sclerotic induration, there were patches of lung tissue resembling catarrhal pneumonia and there were patches of caseous pneumonia. The condition resulted from direct extension and surely was not an ordinary broncho-pneumonia.

(3) Fibroid induration consists, either separately or combined, of long strands of connective tissue which divide the lobes and groups of lobules, which often radiate from the hilus of the lung and which more or less surround the bronchi and vessels; of patches of sclerosis, and of diffuse fibrous changes affecting a lobe or even an entire lung.

(4) In order to be sure of the existence of so-called "syphilitic phthisis," Fowler says the following conditions must be fulfilled:

(a) The case must be complete—that is, the symptoms observed during life must be considered in connection with the lesions discovered on post-mortem examination; (b) the evidence of syphilitic infection must be undoubted; (c) repeated examinations of the sputum must have been made, and tubercle bacilli invariably absent, and the absence of tubercle from the lungs (as the cause of the lesions) must be proved by post-mortem examination; and (d) syphilitic lesions, about the nature of which there can be no doubt, must be found in other organs. This same author cites, among other cases, the following case as illustrative of this *luetie* consumption:—"At the age of eighteen the patient had a sore on the penis, for which he was treated for several months. In 1890, he suffered from cough and expectoration and had an enlarged gland in the inferior triangle of the neck on the right side, dullness at the right apex, with feeble breath sounds, and bronchial breathing in the right supraspinous fossa. The liver was large, nodular, and very tender. He took potassium iodide in gradually increasing doses and obtained some relief. In April, 1893, he noticed edema of the legs and scrotum. He had troublesome cough, with the expectoration of large quantities of extremely fetid pus. The breath was fetid.

Physical Signs.—Expansion deficient on the right side. Relative dullness at right apex, front and back; breath sounds feeble over dull

area. Absolute dullness from level of fifth interspace in nipple line and axilla to base; behind from angle of scapula to base. Vocal fremitus and resonance diminished, and breath sounds audible over dull area. Urine, sp. gr. 1004, contained albumin and fatty casts. The expectoration consisted of frothy, greenish pus, forming thick masses in a watery fluid, and did not contain tubercle bacilli. On May 17, the chest was explored in the axillary and submammary region. No pus was found. May 19, the liver was exposed by an incision below costal arch, and a depressed cicatrix seen. The expectoration continued copious, green, and fetid. Absolute dullness appeared over the whole of right side up to the clavicle, with amphoric breathing and pectoriloquy below clavicle. June 15, offensive pus was evacuated through a cannula inserted in the third right interspace in the mid-axillary line; a portion of the fourth rib resected, more pus evacuated, and a drainage tube inserted. June 19 and 20, hemorrhage from wound. June 21, death."

[Concluded in July issue.]

FINDINGS AND CONCLUSIONS NOT FOUND IN STANDARD WORKS

BY DR. HENRY J. GOECKEL, *Gamma*,

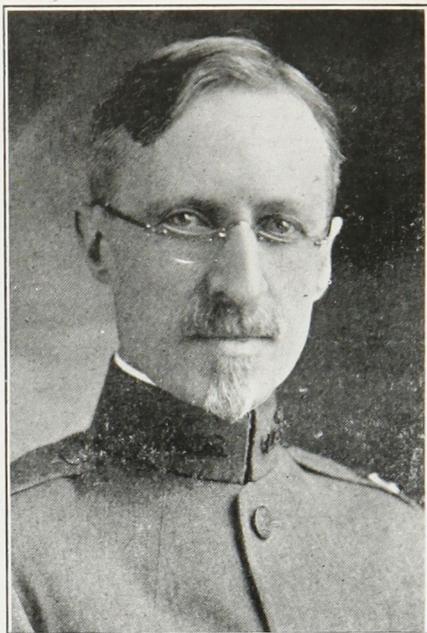
Pathologist and Bio-chemist, Muhlenberg Hospital, Plainfield, N. J.

We all occasionally come across cases and results of laboratory examinations which are of an unexpected nature, sometimes serious, sometimes otherwise. The following urine analyses are such.

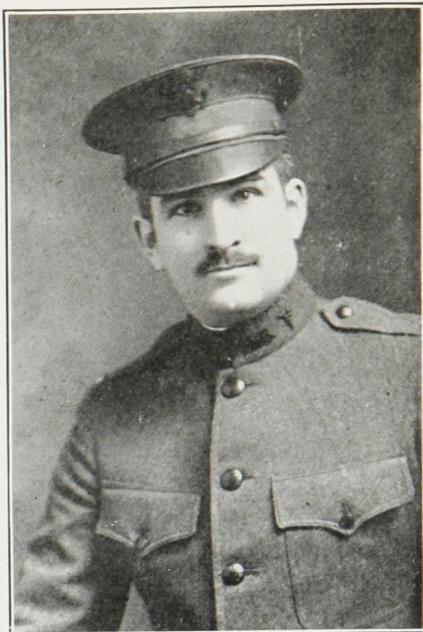
One of the visiting staff of the hospital had an occasion to be consulted by a very select society lady of one of the select residential towns within our zone of service. The patient was apparently suffering from a nervous complex which baffled our friend, who had the patient submit a specimen of her urine to me for examination. The sample showed the following:

EX. 1438G. Mrs. M. H. R.; Dr. R. W. H.; Light normal color, clear; very faint acid; specific gravity 1.011; urea 0.45%. Chemical examination otherwise negative. Microscopically besides a moderate amount of squamous epithelium, a moderate number of isolated leucocytes, a few calcium oxalate crystals and mucus, the most conspicuous thing noted in the sediment from ten CCs (mils) of urine was nine fat and apparently healthy members of the *Pediculosus pubis* family. Another ten CCs after centrifuging showed seven of them, indicating about twenty-five to every ounce of urine. This was the only time I ever reported *Pediculosus pubis* as the result of a urine analysis.

More recently during the time we were blessed for a short stay with an interne from a Grade A college in which we have a chapter, I had another somewhat unusual examination. (The interne was not a



CAPT. A. N. CLAGETT, B.P.,
M. C., U. S. A.



CAPT. P. F. SNYDER, B.P.,
M. C., U. S. A.



LIEUT. A. C. WEAVER, 3rd Class,
Disp. No. 3, Camp Merritt.



CAPT. FRED CRENSHAW, 1st Class,
Menton, France,
M. C. A. E. F.

K Ψ, however.)—He was one of the type who claim a superabundance of practical experience. One, who having given at least a hundred anesthetics, showed his proficiency by using two tanks of nitrous oxide in an endeavor to anesthetise a patient, and who could give ether rapidly enough to choke the patient if allowed to continue. This gentleman had likewise made hundreds of laboratory examinations, but reported pus when amorphous phosphates were present, casts when only epithelial cells were found, and who did not recognise typical uric acid crystals when he found them. During his short stay I received a specimen with the history of a very severe renal colic which two quarter-grain hypodermic doses of morphine failed to relieve. The analysis showed:

#2300G.—Mrs. S.; Dr. T. H. P., 8/1/18. Dark normal color; strongly alkaline; specific gravity 1.032; considerable pale reddish precipitate; distinct albumen test; urea 2.6%. Microscopically chiefly amorphous urates, phosphates, and carbonates. The filtered urine gave a strong effervescence upon acidifying.

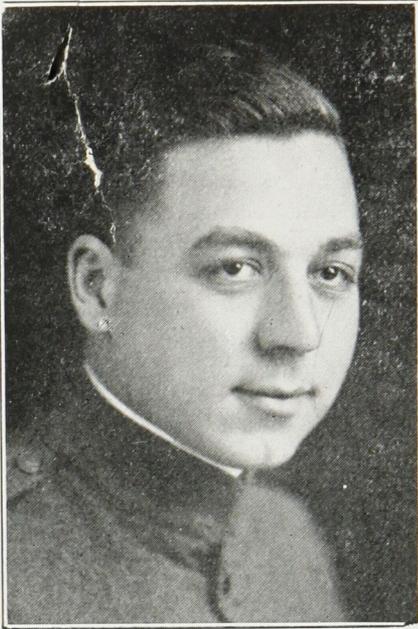
Not to be outdone by the interne, and to spring something on him I was certain he could not claim previous knowledge of, I phoned the following character study to the attending physician as the result of the analysis.

The patient was evidently inclined to be stout, probably a very hearty eater and likewise somewhat vain and disturbed by her tendency to a rotund, good-natured mien. Dr. P. agreed the description fitted the case; likewise that the lady had heard that the juices of the citrus fruits would reduce her weight. So she probably took a too liberal dose of such fruit juices changing the urine to an intensely alkaline reaction, precipitating the phosphates and calcium carbonate in the kidney. The case cleared up uneventfully.

WHEN WATER IS NOT WATER

When you desire your patients to reserve a specimen of urine for examination, don't tell them to place some of their water in a bottle unless you are sure they understand you. The writer recently received a bottle of tap water to examine as the result of just such instructions

H. J. G.



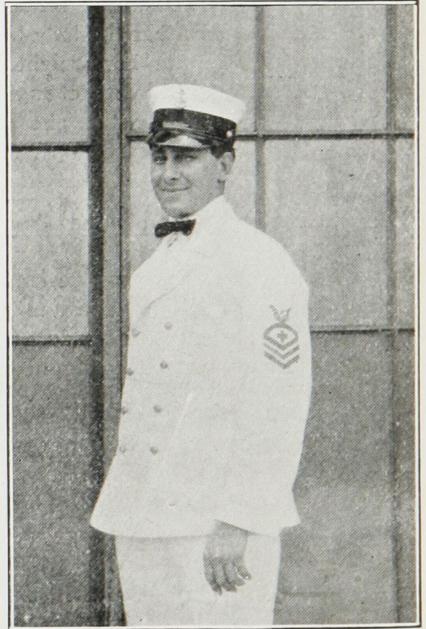
D. F. SIMMONS, X '17,
Med. Det., 123rd F. A., A. E. F.



B. E. SIMMONS, X '15,
3rd Chemical Battalion.



WM. W. KIRK, B-E '19
U. S. N.



G. D. LAVIERI, X '14,
U. S. N.

A BRIEF HISTORY OF KAPPA PSI

Prepared for the New Edition of Baird's Manual

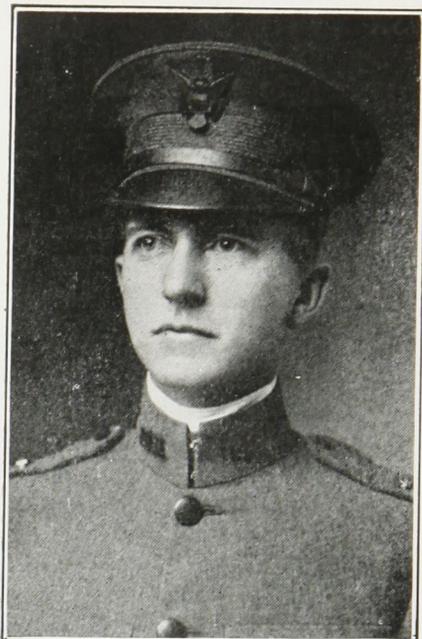
BY DR. A. R. BLISS, JR., G. H. AND E.

Kappa Psi was founded at the Russell Military Academy in New Haven, Connecticut, May 30, 1879, by F. Harvey Smith. It was established on the basis of an older academic society of the same name in which Mr. F. Harvey Smith's father held membership. The organization was entirely literary in its origin and expanded into the following institutions:

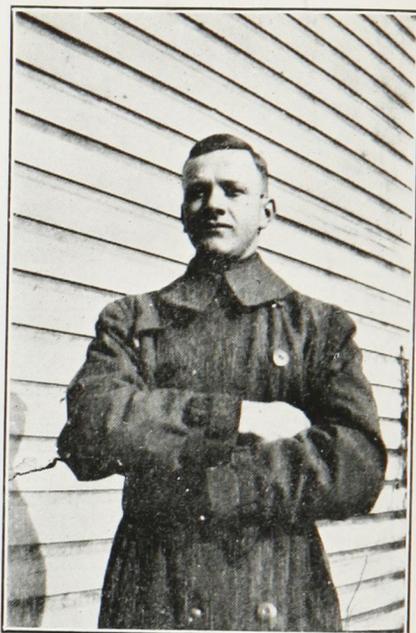
| | | |
|-------|--|----|
| 1879. | RUSSELL—Russell Military Academy (New Haven) | 48 |
| 1879. | CHESHIRE—Cheshire Military Academy (Cheshire, Conn.) | 36 |
| 1886. | HILLHOUSE—Hillhouse High School (New Haven) | 32 |
| 1886. | YALE—Yale College | 14 |

The majority of the members of these chapters entered medical schools, and in 1887 it was decided to establish chapters in medical schools, to discontinue the academic chapters, and to continue as a strictly professional fraternity. The governing body, called "Alpha Chapter," was placed first on the new chapter roll which grew as follows:

| | | | |
|----|-------|--|-----|
| No | 1879. | ALPHA—Grand Council | 5 |
| No | 1887. | BETA—University College of Medicine (<i>now The Medical College of Virginia</i>) | 190 |
| No | 1888. | GAMMA—Columbia University | 484 |
| | 1898. | DELTA—University of Maryland | 421 |
| | 1901. | EPSILON—Maryland Medical College (1914) | 178 |
| | 1902. | ZETA—Georgetown University (1906) | 94 |
| No | 1903. | ETA—Philadelphia C. of P. | 435 |
| | 1904. | THETA—Medical College of Virginia (<i>consolidated with University College of Medicine, 1912</i>) | 20 |
| | 1905. | IOTA—University of Alabama (Mobile) | 203 |
| | 1906. | KAPPA—Birmingham Medical College (<i>now Graduate School of Medicine, University of Alabama, 1915</i>) | 192 |
| | 1907. | LAMBDA—Vanderbilt University | 205 |
| | 1907. | MU—Massachusetts C. of P. | 220 |
| | 1907. | NU—Medical College of Southern Carolina (1914) | 93 |
| | 1908. | XI—University of West Virginia (1914) | 84 |
| | 1908. | OMICRON—University of Nashville (1912) | 86 |
| | 1908. | PI—Tulane University | 238 |
| | 1909. | RHO—Emory University | 230 |
| | 1909. | SIGMA—Baltimore C. of P. & S. (<i>merged with University of Maryland, 1915</i>) | 187 |
| | 1909. | TAU—University of Alabama (Tuscaloosa) (<i>preclinic school discontinued, 1913</i>) | 14 |
| | 1909. | UPSILON—Louisville C. of P. | 121 |



LIEUT. B. A. RUSSELL, K '12, M. C.,
Camp Eagle Pass, Tex.



LIEUT. T. L. ALGEO, B-K '17
A. E. F.



LIEUT. F. M. PATTERSON, B-E '14,
M.D., 113th F. A.



E. D. ARMSTRONG, B-Δ '17,
A. E. F.

| | |
|--|-----|
| 1910. PHI—Northwestern University | 197 |
| 1910. CHI—University of Illinois | 288 |
| 1910. PSI—Baylor University (1914) | 87 |
| 1910. OMEGA—Southwestern University (<i>medical school discontinued, 1915</i>) | 102 |
| 1910. BETA-BETA—Western Reserve University | 131 |
| 1910. BETA-GAMMA—University of California | 197 |
| 1910. BETA-DELTA—Union University (Albany, N. Y.).. | 255 |
| 1911. BETA-EPSILON—Rhode Island College of P. & A. S. | 195 |
| 1911. BETA-ZETA—Oregon State College | 140 |
| 1912. BETA-ETA—Jefferson Medical College | 189 |
| 1913. BETA-THETA—University of Tennessee | 195 |
| 1913. BETA-IOTA—North Pacific College | 97 |
| 1913. BETA-KAPPA—University of Pittsburgh | 620 |
| 1914. BETA-LAMBDA—George Washington University .. | 118 |
| 1914. BETA-MU—University of Louisville | 135 |
| 1914. BETA-NU—Creighton University | 46 |
| 1915. BETA-XI—University of North Carolina | 86 |
| 1916. BETA-OMICRON—University of Washington | 70 |
| 1916. BETA-PI—Washington State College | 47 |
| 1917. BETA-RHO—Loyola University (Chicago) | 120 |
| 1917. BETA-SIGMA—Fort Worth School of Medicine | 29 |
| 1917. BETA-TAU—Marquette University | 24 |
| 1918. BETA-UPSILON—Long Island Hospital Medical College | 30 |
| 1918. BETA-PHI—University of Texas | 18 |

On November 17, 1917, the DELTA OMICRON ALPHA MEDICAL FRATERNITY was merged with the Kappa Psi Fraternity. This organization was founded in the College of Medicine of Tulane University in New Orleans during session 1907-08, and established the following chapter roll up to the time of the merger:

DELTA OMICRON ALPHA CHAPTER ROLL

| | |
|---|-----|
| 1907. ALPHA—Tulane University | 216 |
| 1908. BETA—Columbia University | 84 |
| 1910. GAMMA—University of Tennessee | 129 |
| 1910. DELTA—Southwestern University (1915) | 98 |
| 1911. EPSILON—University of Alabama | 169 |
| 1912. ZETA—Birmingham Medical College (1915) | 77 |
| 1912. ETA—Fort Worth School of Medicine | 128 |
| 1914. THETA—Chicago College of Medicine & Surgery.... | 162 |

(Total Δ O A Chapters, 8. Total Membership, 1063.)

The Delta Omicron Alpha Fraternity published a constitution and by-laws and a ritual. The government was of the usual "Grand Chapter" form and conventions were held annually. The fraternity badge was a triangle of gold and black enamel, with the Greek letters "Delta

Omicron Alpha" in the center of a black enamel field with a star above and a serpent below; the margin was jewelled.

On January 26, 1918, the PHI DELTA MEDICAL FRATERNITY was merged with the Kappa Psi Fraternity. This organization was founded at the Long Island Hospital Medical College in 1901. The chapters were all termed "Alphas" and the roll was as follows:

PHI DELTA CHAPTER ROLL

| | | |
|-------|---|-----|
| 1901. | A-ALPHA—Long Island Hospital Medical College... | 205 |
| 1902. | A-BETA—Ohio State University | 102 |
| 1902. | A-GAMMA—Union University (Albany, N. Y.)..... | 128 |
| 1903. | A-DELTA—Wisconsin College of P. & S. | 78 |
| 1903. | A-EPSILON—Kansas University Medical College (1910) | 54 |
| 1903. | A-ZETA—Washington University | 106 |
| 1903. | A-ETA—Michigan College of Med. & Surg. | 89 |
| 1904. | A-THETA—Sioux City Medical College (1909) | 41 |
| 1904. | A-IOTA—Toronto University (1910) | 31 |
| 1904. | A-KAPPA—Columbia University (1911) | 23 |
| 1904. | A-LAMBDA—Dearborn Medical College (1908)..... | 35 |
| 1904. | A-MU—University of Minnesota | 88 |
| 1905. | A-NU—Chicago College of Medicine and Surgery.... | 140 |
| 1905. | A-XI—St. Louis University | 92 |
| 1906. | A-OMICRON—University of Illinois | 84 |
| 1912. | A-PI—Loyola University | 75 |

(Total Phi Delta Chapters, 16. Total Membership, 1382.)

Each of the Phi Delta chapters rented a house. The fraternity published a yearbook called *BLACK AND GOLD*, a ritual, and a constitution and by-laws. The government consisted of the usual "Grand Chapter," and conventions were held triennially either in New York or in Chicago. The fraternity badge was a monogram of the fraternity letters "Phi" and "Delta," with the former superimposed over the latter and the chapter letters inserted in the ring of the letter "Phi." The flag was a black pennant with a red Geneva cross in the center, with the fraternity letters in gold to the right and left of the cross.

The following chapters of Kappa Psi were formed from local organizations: *Eta* from Delta Gamma Phi; *Upsilon* from Pi Mu; *Phi* and *Chi* from the Alpha and Beta Chapters of Phi Gamma Sigma; *Omega* from Kappa Lambda; *Beta-Epsilon* from Psi Beta; *Beta-Kappa* from the Beta Chapter of Beta Phi Sigma; *Beta-Omicron* from Beta Psi; *Beta-Pi* from Sigma Gamma; *Beta-Rho* and *Beta-Sigma* from the Eta and Theta Chapters of Delta Omicron Alpha; and the Alpha-Nu and Alpha-Pi Chapters of Phi Delta; *Beta-Upsilon* from Alpha-Alpha of Phi Delta; the *Phi Zeta Delta* Fraternity was merged with *Eta* in 1917.

Thirty of the chapters rent chapter-houses.

The alumni of the Fraternity are organized into graduate chapters which have the same rights and privileges as the collegiate chapters. They are termed "Graduate-Beta," "Graduate-Gamma," etc., as follows:

- 1906. GRADUATE-BETA—Philadelphia, Pa.
- 1907. GRADUATE-GAMMA—New York, N. Y.
- 1907. GRADUATE-DELTA—Baltimore, Md.
- 1908. GRADUATE-EPSILON—Birmingham, Ala.
- 1910. GRADUATE-ZETA—Chicago, Ill.
- 1912. GRADUATE-ETA—Boston, Mass.
- 1913. GRADUATE-THETA—Albany, N. Y.
- 1913. GRADUATE-IOTA—Providence, R. I.
- 1913. GRADUATE-KAPPA—San Francisco, Cal.
- 1914. GRADUATE-LAMBDA—Cleveland, Ohio.
- 1915. GRADUATE-MU—Atlanta, Ga.
- 1916. GRADUATE-NU—New Orleans, La.
- 1916. GRADUATE-XI—Mobile, Ala.
- 1916. GRADUATE-OMICRON—Dallas, Texas.
- 1917. GRADUATE-PI—Greensboro, N. C.
- 1917. GRADUATE-RHO—Washington, D. C.
- 1917. GRADUATE-SIGMA—Nashville, Tenn.
- 1917. GRADUATE-TAU—Memphis, Tenn.
- 1917. GRADUATE-UPSILON—Richmond, Va.
- 1918. GRADUATE-PHI—Columbia, S. C.
- 1918. GRADUATE-CHI—Brooklyn, N. Y.
- 1918. GRADUATE-PSI—Portland, Ore.

(Graduate Chapters, 22.)

RECAPITULATION OF CHAPTERS

| | |
|--|----|
| Kappa Psi Academic Chapters (<i>discontinued 1887</i>) | 4 |
| Kappa Psi Collegiate Chapters | 44 |
| Delta Omicron Alpha Fraternity Chapters (<i>merged 1917</i>).... | 8 |
| Phi Delta Fraternity Chapters (<i>merged 1918</i>) | 16 |
| Kappa Psi Graduate Chapters | 22 |
| <hr/> | |
| TOTAL..... | 94 |

MEMBERSHIP

| | |
|---|-------|
| Kappa Psi Membership | 7,255 |
| Delta Omicron Alpha Membership (<i>merged 1917</i>) | 1,063 |
| Phi Delta Membership (<i>merged 1918</i>) | 1,382 |
| <hr/> | |
| TOTAL..... | 9,700 |

The Fraternity is divided into five provinces known as the Phi Delta or North Atlantic Province, the South Atlantic Province, the Middle Atlantic Province, the Delta Omicron Alpha or Middle West Province, and the Pacific Province. It publishes its Constitution and By-laws; *The Agora*, an esoteric publication which contains the directory and

which was published annually from 1903 to 1910 and since then every three years; *The Mask*, a periodical, issued every month during the college year from 1903 to 1910, and since then issued as a quarterly; *The Ritual*; a songbooklet; and chapter secretary's books.

The Fraternity is governed by "Alpha Chapter" or the Grand Council which has met in annual conventions from 1886 to 1908, and since then biennially. During the interim between sessions, the administration of the fraternity affairs is in the hands of the grand officers. Conventions have been held at New Haven, 1886 to 1898; New York, 1900, 1905; Baltimore, 1901, 1902, 1906; Richmond, 1902; Washington, 1903; Philadelphia, 1904, 1907; Charleston, S. C., 1908; Birmingham, Ala., 1910; Chicago, 1913; Atlanta, 1916. The provinces meet in biennial conventions on the alternate years to the national conventions.

The fraternity colors are scarlet and cadet grey. The flower is the red carnation. The badge is a diamond displaying a mask raised from the face of the black enamel center. The Greek letters "Kappa" and "Psi" appear one above and one below the mask. The eyes of the mask and the border of the badge may be jewelled.

A NEW USE FOR MEDICAL JOURNALS

If ever you are on a country road and run out of gas and upon securing some gas find you have no funnel, don't despair if you have a copy of one of the medical journals in the car. It will make an excellent funnel, I am told by one who has tried one for that purpose.

H. J. G.

When a doctor advises his patient to stay home "of a week-end and rest," and at the same time prescribes ten one-tenth grain doses of calomel at quarter-hour intervals followed by a saline laxative in the morning, he ought to be made to take a dose of his own medicine to see if he would call it a week-end and rest or just a "weak end." He might think it more of a hallowday than a holiday.

H. J. G.