The Society of Civil War Surgeons

Journal

1ST QUARTER 2024
Our 28th Volume

WWW.SOCIETYCIVILWARSURGEONS.ORG

IN THIS EDITION:

The Society promotes education and understanding of the Medicine prior to, during, and after the American Civil War. It focuses on the medical techniques, medical innovations, and general medicine of the time period.

President's Perspective:

2024 is going to be another great year for The Society. The Charleston Gathering was sold out in 35 days. This next year, in 2025, we are going to Atlanta, Georgia. The Atlanta History Center is just one of our field trips on Friday. The Center contains the Smith Family farm (a working farm during the war), the Cyclorama of the Battle of Atlanta, and the History Museum with thousands of artifacts from a southern perspective. Please sign up early! The information will be sent to all current members in early April, 2024.

We are now seeing a new generation of Surgeons starting to appear in reenacting. One of the critical medical components they are all looking for is a reproduction, capital amputation kit or a pocket kit. With Ed Archer kits, not being produced in years and Milk Creek kits in the same situation many new Surgeons are desperate to find a kit to use in their demonstrations. The Society is starting a program called "Members to Members." If there any members who are ready to "hang up their scalpels & bone saws" please let us know by sending an email to us at societycivilwarsurgeons@gmail.com.

The Society office has a list of Society members who would like to purchase your reproduction kit and continue the critical education of the public using your gently used capital kit or pocket kit.

If any Society member would like to be added to the list for a kit when it becomes available, please email us and we will add your name to the list of those seeking kits.

We hope that "Members to Members" will allow us to help a new generation of "Civil War Surgeons" continue the education of future generations with these intergenerational medical kits.

Our cover picture this month is from Washington City. Note the gas jets hanging from the pipes to light the ward at night. These are patients in Ward K at Armory Square Hospital in August 1865.

If you have not visited our website or joined our Facebook site, please do so soon. Their URL's are: www.societycivilwarsurgeons.org and Society of Civil War Surgeons at Facebook. Both are searchable on the web.
Our email is societycivilwarsurgeons@gmail.com

Most Respectfully,
Your Obd.'t Serv't.
Trevor T. Steinbach Ed.D

The Journal of Civil War Medicine [ISSN: 1545-4975] is published quarterly in February, May, August, & November by The Society of Civil War Surgeons, Inc. and is available through membership in The Society. The journal is totally an electronic, on-line publication.
The office of publication is located at 129 Lively Stream Way, Gettysburg, PA 17325

ADVERTISING: All advertising should be submitted to Publisher, at the above address. Advertising rate sheets are available upon request.

ARTICLES: All articles should be submitted to Publisher, at the above address. We assume no responsibility for unsolicited manuscripts not accompanied by return postage. Articles and Letters to the Editor become property of The Journal of Civil War Medicine. If published, we reserve the right to edit at our discretion.

SUBSCRIPTION: Individual: $35/year or $85/three years. Family: $55/year or $135/three years plus credit card fees if applicable.

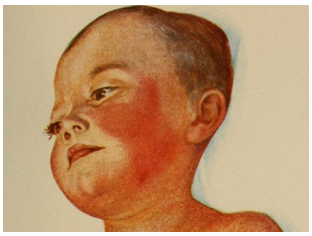
POSTMASTER: Please send all address changes to The Journal of Civil War Medicine, The Society of Civil War Surgeons, 129 Lively Stream Way, Gettysburg, PA 17325
THE SOCIETY OF CIVIL WAR SURGEONS is incorporated in Pennsylvania as a non-profit, educational organization devoted to advancing the knowledge and understanding of Civil War era medicine, surgery, and the treatment of the sick and wounded. It publishes The Journal of Civil War Medicine, fosters fellowship, provides a continuing forum for education and the exchange of information, sponsors meetings and exhibits; collects and preserves source materials; and serves as a resource for those seeking authoritative information about Civil War medical and surgical practices, as well as the treatment of the sick and wounded

A MONOGRAM ON SCARLET FEVER – BY EDWARD H. PARKER M.D., LATE PROFESSOR OF ANATOMY AND PHYSIOLOGY IN THE NEW YORK MEDICAL COLLEGE, 1859

In the spring of 1863, all three of Major General Longstreet's children died from Scarlet Fever that went through the children in Richmond, VA
We start this Journal with the 1859 reprint on Scarlet Fever.

Other than Scarlatina, no disease calls forth from physicians a greater variety of opinions as to its pathology, its treatment, and especially its malignity. Some do not hesitate to say that they encounter it without fear,°are sure of success in treating it, and only wonder at, if they do not openly blame, those who confess that they dread its approach, are constantly uncertain of its result, and not unfrequently lose their patients. It ought, then, to continue to be an interesting topic to medical men.

The three distinctive peculiarities of scarlatina which separate it from the other exanthemata (the fact of its being an exanthem dis tinguishes between it and other diseases) are the eruption, the sore throat, and the frequent pulse, and I therefore proceed to consider each of these separately.



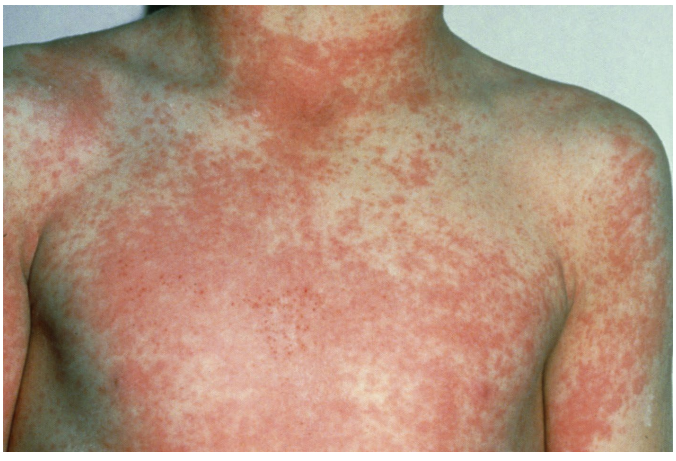
I. The Eruption.—This is of a red color, varying from a pure and distinct scarlet to a color which has a decided brown, mixed with the scarlet. I do not intend to say that it is a deep and marked brown, but it can be imitated in water-colors, by adding to the vermilion more or less of the yellowish-brown color, known as burnt sienna. The vermilion has to be toned by the sienna to produce it. This coloring of the surface is not caused by a smooth and equal injection of the superficial capillaries; and thus differs entirely from erysipelas, or any other inflammatory blush quite minute, but distinctly preserving a general conical figure, so long as they are not so much crowded as to become confluent. This shape can be seen when they are sufficiently isolated either upon the skin, or upon the mucous membrane of the mouth.

As the disease progresses, and the eruption develops itself more and more fully, it loses its distinctness, either by the gradual expansion of the base of the cones, as may be seen in mild cases, or by the too near approximation of neighboring cones, crowding all into a uniform and confused flat mass. Still, in this case, there will be found to be some prominences, as if a few cones of unusual height still continued to project from the otherwise level surface; but they are few in number, as compared with the preceding abundance of them, though sufficient to give to the touch that sensation of roughness which is characteristic of the distinct stage.

The period at which the eruption makes its appearance is very variable. I have seen it quite apparent, and already becoming confluent, within half an hour of the time at which the patient first gave any signs of being ill; and I have seen cases in which it did not appear at all. As a general thing, however, it may be said that the eruption makes its appearance within forty-eight hours of the time in which the patient begins to feel unwell. The place in which it first makes its appearance externally is also inconstant. The neck and upper portions of the chest, the inside of the elbow-joints, the groins, and be-neath the knee-joint, are the favorite locations, and in those it is to be sought. Before the appearance of the eruption in any of these places, it can often be seen upon the mucous membrane of the mouth, particularly that which covers the soft palate, and upon and about the tonsils.

The facility with which sufficient light can be thrown upon this surface to enable one to inspect it thoroughly, and the ease of the examination, leave no excuse for neglecting to look at it in all suspected or doubtful cases. There can rarely be any occasion for confounding it with the eruption of measles; which, although it may be seen in the same locality, is of a pink color, and presents in its patches the crescentic form. An intense tonsilitis may more reasonably lead to some doubt or confusion; but, although the tonsils are in both cases highly colored, as well as the soft palate, a careful inspection will enable one to see that the scarlatinal throat is roughened by the eruption,

roughened by the eruption, while that of simple tonsilitis is highly injected, but smooth. But, wherever the eruption first makes its appearance, it increases, in cases of a typical character, (that is, in those which present no anomaly,) for two or three days in intensity, and then, gradually becoming duller and duller, fades away. During its increase, it gives an increased fullness to the whole surface, which is chiefly apparent on those parts which are of great mobility. Thus the cheeks are stiff, the eyelids are not precisely heavy, but feel thick when raised, the fingers when beat feel clumsy, aod the band seems to be covered on its palmar surface with a thicker and denser skin. As the eruption disappears, there is a corresponding disappearance of fullness; and when it has entirely gone, the shriveled appearance is quite as marked as was the previous swelling. Then the cuticle begins to separate, coming off in large pieces where it is thick and firm, as upon the palms of the hands and the soles of the feet; from both of which it sometimes separates itself in a mass, as it were a cast of the surface. From the body it falls off in a more pulverulent way; not, apparently, from any difference in the effect of the eruption upon the cuticle, but because the constant friction of the clothing reduces it at once to powder. Upon the completion of the process of desquamation, for which no definite period can be fixed, varying, as it does, with the intensity of the eruption and the vigor of the patient, convalescence is gradually established, and health returns to the patient.



II. Of the Sore Throat.—Mention has been made of the early appearance of the eruption in the faces and throat. Corresponding with this is the fact that, from its presence, the contraction of the muscles of the throat becomes disagreeable, from a feeling of stiffness which results from it. But the tonsils are the portions most affected by the disease, and not only present the red appearance before described, but soon become enlarged, projecting into the throat, so as to interfere both with deglutition and phonation. It is, in fact, often easy to tell what is the condition of the tonsils as to size, before examining the throat, merely from the change which they produce in the voice. When much enlarged, the effort to swallow produces severe pain, which is referred directly to the region of the tonsils as its seat. Still, there is not usually at this period any ulceration of the tonsillar surface, to which, by its contact with the fluids or solids attempted to be swallowed, the pain can be referred. Externally, these glands are felt very distinctly, and pressure upon them causes pain. In typical cases, pure and simple, the redness, the swelling, and the painful deglutition continue for about a week, when they gradually lessen and pass away. But in many other cases, ulceration of the tonsils occurs, sometimes to a fearful extent, grayish-white patches present themselves upon other portions of the mucous membrane, or a proper diphtheritis sets in, greatly periling the life of the patient. But these will be spoken of elsewhere as complications.

III. Of the Pulse.—More constant and reliable intimations of the presence of scarlatina may be derived from the pulse than any other single symptom. From the first, it is remarkably frequent, rising in the adult to 120 beats a minute almost with the first signs of illness, and soon reaching, in some cases, 140 or 150 beats. It is by no means the pulse of inflammation, but is quick, almost irritable, as if there were an excessive exaltation of the innervation of the heart. It is easily obliterated by pressure, never forcing its way under the finger against decided resistance, but instantly returning with its quick, sharp motion, when that pressure is lessened. When both the eruption and sore throat are absent, as is sometimes the case, the pulse will, by these characteristics, give quite reliable indications of the disease; while the absence of these peculiarities of the pulse will often enable one to avoid mistaking a cynanche, or a roseola, or even a rubeola, for scarlatina. It is hardly necessary to say that an early and accurate diagnosis is often of material importance, not only for the reputation of the

physician, but for the safety of others who may be exposed to the contagion, or to allay the fears of anxious friends.

Accompanying this condition of the pulse, we have a dry, hot, pungent-feeling skin, which gives to the hand, firmly applied to it, a sensation which might almost be said to be tingling. It is similar to, though more pungent, than that felt when the hand is placed upon the thorax of a patient suffering from a violent pneumonia.

I proceed to fill up the portraiture of the disease, the outline of which has thus been sketched.

The most common subjects of this disease are children under twelve years of age; those who have gone beyond that time without suffering from it being less and less liable to an attack, as their age increases Something of this immunity from age alone is probably due to circumstances, and more apparent than real. In this country, at least, few persons live twelve years without being exposed more than once to an epidemic of scarlatina. If, then, at that age, one has not had that disease, the probability is that he is not so susceptible to it as are the majority of children. And yet, two facts seem to show that when there has been no previous exposure of persons arrived at adult age, they are not so liable to be attacked by an epidemic as young children. The first of these facts is drawn from a paper by Dr. William Douglass, describing what appears to have been the first epidemic of this disease in New England, and probably the first in this country. Dr. Douglass says, that " in November (1858) it spread considerably in Boston, especially among children," while throughout the whole paper the patients are usually spoken of as children.

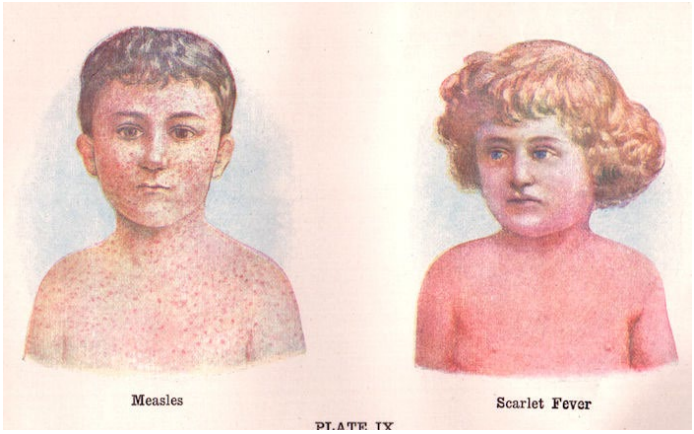


PLATE IX

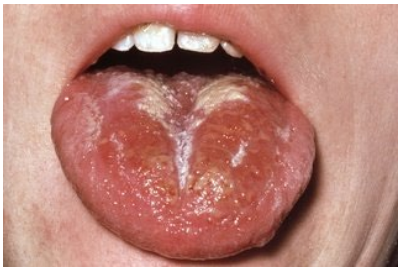
The second fact is drawn from a statement made by Dr. Copland, at the meeting of the Royal Medical and Chirurgical Society, held at London, on the 10th of November, 1858, when scarlatina was the topic under discussion. That gentleman stated, that of the patients who had scarlet fever at the Cape of Good Hope, which had not previously been visited by the disease for twenty-three or twenty-five years, " many had arrived at adult age." If It may here be noted, that of adults it is especially apt to attack pregnant females, and is attended with unusual danger to them, causing a premature expulsion of the foetus, and frequently the subsequent death of the mother.

Scarlatina resembles the other exanthemata in that it usually occurs but once in the same patient, but is also like them in that it may recur once and again, even after the first attack has been marked with a good degree of severity. So many instances may be found in the practice of almost every one, proving that scarlatina is communicable from one individual to another, that it is unnecessary to quote illustrations of it. It is admitted as a fact. That it may be conveyed in clothing is not so generally admitted, and yet my own opinion is very decided, that it may be so communicated. As illustrations of this, reference may be made to a fact which Dr. J. K. Mitchell, of Philadelphia, was accustomed to quote in his lectures. A frock, which belonged to a little girl who was sick with scarlet fever, was sent to be tried on by another little girl, whose mother borrowed it for that purpose, being ignorant of the illness of her friend's child. Without any other known exposure, the second girl, in a few days, broke out with the same disease. I am quite confident that there was no epidemic prevailing at that time. A more marked instance has been communicated to me by a medical gentleman, in whose family it occurred. A servant left his house to attend upon the children of her sister, who were ill with scarlatina. After they had recovered she returned to his house, remaining but a few days, and leaving, upon her second departure, a bandbox in the room which she had occupied. Mrs. opened the box to see what it contained, and, finding that it was the servant's clothes, immediately closed it again. In a few days Mrs. was attacked by scarlatina. The clothes, upon servant had worn while acting as nurse with her relatives, and which had been

packed up by her without any washing, or even airing. Mrs. did not touch the clothes, and kept the box open only a moment; but being very near-sighted, was compelled to bring her face close to it, to ascertain its contents. There had been no other exposure, for the disease was not epidemic at the time, and she knew no families in which it could have been communicated to her. It is proper to add, that her husband, Dr. , was not engaged in the practice of the profession, and the disease was not brought home by him.

It is probable that scarlatina occasionally springs up anew without the previous existence of the disease from which it could have been generated. A fact within my own knowledge, in which, in three successive years, children of families living in adjoining houses were in the same month of each year attacked by the disease, seems to suggest that there may have been some telluric or atmospheric condition which required only the ripening influences of the month of May to bring forth its fruit in disease. The many possibilities of error in the case, especially as to any contagious communication, forbid argument from it. Dr. Douglass, in the paper which I have already referred to, says, in speaking of the epidemic which was observed by him, "This distemper did emerge 20th May, 1735, in Kingston Township, 50 miles eastward from Boston; it was no foreign importation, Kingston being an inland place, of no trade or considerable communication."* The period of incubation of this disease is very uncertain: in some cases it appearing to be only a few hours; in other cases, many days. One of the most striking illustrations of this is given by Dr. Jacob Bigelow, of Boston. In one of the notes appended to his paper on self-limited diseases, that writer says: " I knew a patient to be taken with scarlet fever in forty-eight hours after arriving in this country, by a passage of forty days from Europe. In this instance, as no case existed in the ship, the latent period must have been less than two days, or more than forty." As a general rule, it is safe to say that, if an exposure to the disease is known or suspected, and a fortnight has since passed without the appearance of the eruption or other symptoms, all apprehension of danger may be laid aside. The first manifestations of the disease are, usually, sickness at the stomach and vomiting, frequently occurring very suddenly, and with out premonition. Thus, a child may awake from a quiet sleep and immediately vomit, the other symptoms following in rapid succession. Headache may precede, accompany, or follow the vomiting, it rarely being absent. The pulse is almost immediately found to be frequent, and to present those characteristics which have already been mentioned. The skin becomes hot and pungent, and may even then, if carefully examined, be found to present the eruption. The fauces may also participate in this condition, and not only be dry, but so swollen and tumefied that deglutition is seriously embarrassed. Occasionally, the stiffness of the throat and difficulty in swallowing will appear before any of the other symptoms. Delirium is often observed from the very first appearance of the disease ; and scarlatina is, in this respect, peculiar among the exanthemata. This " wandering " of the mind will not usually be apparent, in the early stages of the disease, while the patient is fully awake, but during his sleep, and especially when waking from sleep. It is a delirium of talking, rather than of doing. When first aroused from sleep, the patient is loquacious, using the most iaappropriate words, or talkiug of very different subjects from those on which he is questioned. In a moment or two, if fully awake, this usually passes off, and he is found to be in the entire possession of his faculties.

The condition of the tongue is of great interest. More reliance has, however, been placed upon its changes than is safe or correct. At first, a thick, white coat spreads over the surface. This is soft, moist, and pasty. After a longer or shorter time, (in one case a few hours, in another a day or two,) red points begin to show themselves through the white coating. These are the elongated and nude pa pillae, and by their position give to the surface a striking resemblance.



to that of the white strawberry. As the case goes on, this white coating separates itself, and, disappearing, leaves the tongue of a scarlet hue, rather dry, and with the papillae still very apparent. The resemblance is now to a red strawberry, though, to my own eye, it is not quite so striking as that to the white. The diagnostic value of this appearance has been overestimated. The projecting papillae are not unfrequently seen protruding through a white coat in gastric and enteric fevers. While writing, I have under my care a child with gastric fever, whose tongue resembles a red strawberry, though its color is not quite so bright as in scarlatina.

As to the bowels, there is sometimes a decided constipation; at other times there is a diarrhoea. This variation is important, and to be remembered; for cathartics, and especially active ones, are by no means to be used indiscrimioately. The prostration produced by them sometimes adds fearfully to the dangers of the disease. Thus commencing, scarlatina goes on in a constant manner. The eruption increases in its extent until the whole surface is covered, and deepens in its color until the disease begins to decline. At this time the fever diminishes, the pulse becomes less frequent, the heat abates, the thirst lessens, and the whole condition of the patient improves. The throat, however, continues to be painful for some time after there has been a decided amelioration in all other respects. The delirium, which increases at night so long as the fever increases, and, in cases of a grave character, may be continuous through the day, lessens as the disease abates, but still occurs occasionally at night, till convalescence is fairly established.

Thus I have sketched what may be termed a typical case of the disease, one presenting all its characteristics, and terminating in recovery, without any hindrance to its regular progress. Now, it is necessary to say that such cases are comparatively rare. This regular beginning, rise, progress, and decrease are often seen, but much more frequently there is some departure from this course. These variations, these departures, may be in any part of the disease, and in every particular, from the beginning to the end of the attack.

Many are the instances, not only where death has occurred in consequence of them, but, when this has not happened, they have changed the whole life's prospects.

REPORT OF, THE EVENTS CONNECTED WITH THE FIRST BULL RUN CAMPAIGN. W. S. KING, Surgical Director, U.S.A.

Having a few weeks previous arrived in Washington, from a distant frontier station, I was detailed to report as Medical Director, to the General in command of the Department of N. E. Virginia. Upon reaching the headquarters at Arlington, where our forces were assembling, I became painfully impressed with the vastness of the work to be done, to prepare for the coming conflict, and the very short time, apparently, that would be allowed for the purpose. 1 found the army with which we were to meet the enemy, to be composed of the best, and also of the worst material I had ever met with. This force had been hastily collected ; many of the men had never been examined by medical officers, and were inferior to those in the regular army, where the physique is more carefully regarded.

In the Bull Run campaign, Surgeon Magruder and myself were, with few exceptions, the only medical officers who had previously served with troops, and our advice and assistance were eagerly sought in relation to the details of camp life and " the mode of procuring the necessary medical supplies. In pre-paring for the expected battle, a limited number of

ambulances which had been furnished, was distributed with great care, so as to equalize the amount of transportation among the regiments. I made an estimate of twenty wagons for our medical supplies, which, although approved by the commanding officer, did not result in their being sent. A few days before the forward movement, directions were issued by the General commanding, to have the army put in light marching order ; that all officers and soldiers should carry with them three and a half days cooked rations, and that all baggage and stores of every kind should be left behind in camp, to be subsequently sent for. As the conveyances estimated for had not been furnished, these arrangements made it impossible to transport any medical supplies except such as could be placed in the ambulances or poked into the forage wagons, and this I directed the medical officers to do.

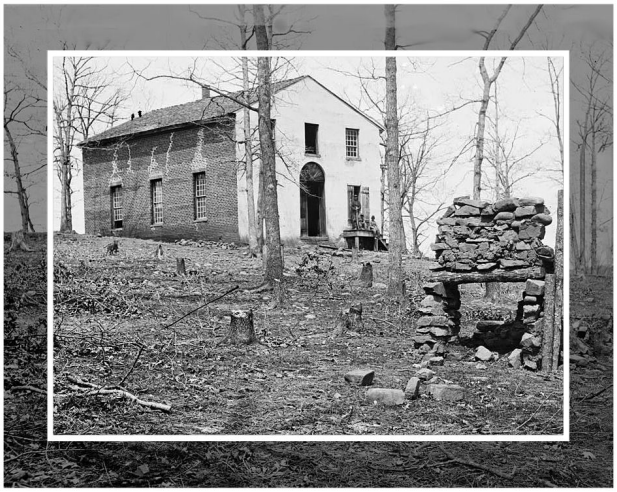
We pursued our course on the road leading to the Ford, and soon met the ambulances with the dead, wounded and disabled men. One soldier had had his face shot away completely. Some in the ambulances were not wounded, but were disabled from sunstroke or exhaustion. The ambulances were stained with blood, evincing the terrible earnestness with which the rebels had commenced their struggle. I immediately dispatched Surgeon Magruder to accompany the forward ambulance to Centreville, and to select suitable buildings, for hospital purposes, and I followed him with the remainder, after picking up all the wounded we could find. A hotel, a church and a large dwelling, were selected by Dr. M., and a portion of the wounded was placed in them before my arrival.

By 9 o'clock P. M., through great exertion, on the part of Dr. Magruder and myself, we succeeded in organizing to some extent, our impromptu hospitals. Several amputations were performed, one, I remember, of the thigh, which resulted fatally the next day, and one of the leg which did well.

Surgeon Magruder and myself made frequent visits to all the hospitals, assisting in their organization and operations, and helping to make the wounded as comfortable as our means would admit of. This task we completed near midnight, and completely

daylight, we sallied out to find our camp at headquarters, wherever that might be. The 19th and 20th of July were occupied in camp, waiting for the arrival of subsistence. We embraced the opportunity to repair our ambulances and again visit the hospitals at Centreville. Sensible of the want of additional medical supplies which would be needed in the event of the expected battle, and know ing that the sympathy of the entire country had been aroused to the importance of providing with the utmost liberality for our sick and wounded.

On the morning of July 21, 1861, the General commanding, accompanied by his staff, passed, at daylight, through our columns, already moving in the direction of Bull Run. The weather was excessively hot, and, as one of the causes of the Bull Run failure, I desire to record my belief that the exhaustion of our forces, by the long and forced march, contributed as much as anything else to the disasters of the day. The comparative freshness of the rebel troops gave them great and decided advantage. It is often the case that on what may be termed little things, if there can be such in a battle, the fortune of war depends. I found the medical officers, as a gen eral rule, on the alert, and many performing their duties cooly under the fire of the enemy. Soon I became convinced that a most desperate engagement was at hand, and I directed Surgeon Magruder who had thus far remained at the headquarters, to proceed to Sedley Church, which was near by, yet out of the line of fire, and to prepare it, and if necessary, a couple of houses close to the church, for the reception of our wounded, and to send for ward the ambulances as rapidly as possible.



These orders were promptly executed, and the drivers brought their conveyances as close to the points where the wounded were as the nature of the ground would permit. Having my saddlebags well supplied with instruments, dressings, etc., I found frequent occasion for their use in restraining hemorrhage and relieving exhaustion and suffering on the spot where the wound was received.

We arrived at Centreville, tired and disappointed, near sundown. Here we waited for the coming of our straggling troops. After sending them on in advance, followed by all the wagons, we left at half-past ten o'clock P. M. for Fairfax, where we intended to remain till morning. The weather for some time past had been excessively dry and hot, and the dust of the turnpike, between Centreville and Fairfax, raised by our soldiers and wagons in passing, floated ove.1 the road like a thick fog, and made it impossible to see for a dis tance of more than ten paces.

A few days after the battle, General Wadsworth entered the enemy's lines to bring away the remains of one or two distinguished officers, and also to succor, and, if possible, to remove our wounded. I, and Assistant Surgeon Schell, U. S. A., followed with thirty-nine ambulances, and arrived at midnight at Bailey's Cross Roads, which was in possession of our pickets, there to await the return of the general, when we were to be informed of the result of his mission

At daylight next morning, finding that he had not come back, I took several ambulances and proceeded to the rooms of the Sanitary Committee in Washington, and procured everything that I thought would be required for wounded men on the way, and hastened back again to Bailey's Cross Roads. Arriving in that vicinity, I met Dr. Schell with the remainder of the ambulances, proceeding back to Washington. He informed me that the General had completely failed to obtain the permission desired, and that the enemy's cavalry having driven in our pickets, he was fearful lest the ambulances with their supplies should be captured. All the knowledge gained, was that the wounded would probably be removed to Richmond. A few days after, I was ordered to report for duty, with General Banks' division, and I therefore close this narrative. I am aware that the medical history of this campaign is very meagre ; yet, imperfect as it is, it may serve as a record of events not supplied by other reports. W S. KING, Surgical Director,
U. S. A.

The following very imperfect resume is appended : 1st. Our troops in the action of the 18th of July, 1861, were exposed to the fire of artillery at long range. In the battle on the 21st of July, 1861, of Buli's Run, the troops were exposed to the fire of artillery and musketry at long and short range. Duration of battle, seven hours. 2nd. The casualties of the action at Blackburn's Ford, July 18th, 1861, were as follows, (approximate) Killed 10 Wounded 33, Aggregate, 43. Three of the wounded died within twenty-four hours after the reception of the wound. The wounded in the above action were sent on the evening of the 20th of July in ambulances Alexandria. 3rd. Many of the wounded of the Bull Run fight found their way to Alexandria, and accompanying our army in its retreat were helped along to the hospitals in the vicinity of Washington; many who gave out by the way, were brought in the day following in ambulances sent out for them. I can form no idea of their number. Immediately after the action, I directed the Regimental Medical Officers to send in a report of the casualties of their respective regiments. As large numbers who were at first reported killed are found to have straggled, only, a long time usually is required to obtain correct results after a battle, I was ordered to join Genl. Bank's division before reports were received sufficient for an approximation even. I must therefore refer you to reports of Genl. McDowell, or to Surg. Magruder, U. S. A., who remained with the command. The wounded during

the action were removed from such portions of the field as were accessible, to Sedley Church and vicinity, as described in the report of Surgeon Magruder. The maps will show the situation of this Church. I am unable to make any report as to our wounded on the field in possession of the enemy, and have no knowledge as to where they or those left in the hospital at Sedley Church and buildings near by, were removed. The report of the General Commanding will show the strength of the command. W. S. KING, Surg, and Med. Director.

TEETH. AN IMPROVED METHOD OF CONSTRUCTING ARTIFICIAL DENTURES COMBINING FIVE IMPORTANT POINTS NOT HERETOFORE ATTAINED. TOGETHER WITH DIRECTIONS FOR THE DEVELOPMENT AND SUBSEQUENT PRESERVATION OF THE NATURAL TEETH. By Dr. J. Allen Ohio College of Dental Surgery 1860.

More than two thousand years have elapsed since artificial teeth were first worn by man, during which time dental science has been gradually developing and approaching nearer perfection. The combined skill and experience which have been accumulat-ing in the dental art during this period, brings to our aid well attested principles, by means of which we are enabled to approach still nearer the culminating point.

The improvements herein referred to consist—
1st. In having the teeth garnished with an indestructible artificial Gum, Roof, and Ruga of the mouth without seam or crevice, with all the delicate tints and shades peculiar to those of nature.

2d. The sunken portions of the face are restored to their original fullness, thus rejuvenating the waning cheek, which cannot be done by the usual mode of inserting artificial teeth

3d. The inside of the teeth and gums have the same form as the natural organs ; to this form the tongue is readily adapted, and the enunciation becomes clear and distinct.

4th. A truthful expression is given to the teeth and mouth which make them appear in perfect harmony with the other features of the face.

5th. No metal plate can be seen in gaping, laughing or speaking, for the teeth are firmly set in the artificial gum, which also covers the plate and represents the natural roof. This gum consists of a silicious compound which is applied and fused upon the teeth and plate in such a manner as to fill up the interstices around the base of the teeth, and unites them firmly to each other, and to the plate upon which they are set. Hence there can be no foul secretions to vitiate the saliva or infect the breath.

The importance of a sweet and healthy mouth will be readily perceived in view of the fact, that the food which is taken into the system is moistened with the saliva ; and if this be vitiated, either from an unhealthy condition of the salivary glands, or by contact with filthy dentures, it exerts a baneful influence upon the stomach and alimentary canal, and impairs the general health in a greater or less degree. A pernicious effect is also produced upon the system by inhalation. A person inhales atmosphere 20,000 times every twenty-four hours. If this becomes polluted by the foetor, which is constantly being emitted from impure dental or gans, (either natural or artificial,) it does not impart to the system that invigorating principle which promotes health.

The object of respiration is to convey fresh atmosphere to the iungs for the purpose of arterializing the blood. If the atmosphere be impure, the blood will not be purified; in consequence of which, the blush of the rose leaves the cheek, and the hue of the sear and yellow leaf takes its place.

Again, the exhalations, from persons whose mouths are not in a sweet and healthy condition, renders them offensive to others.

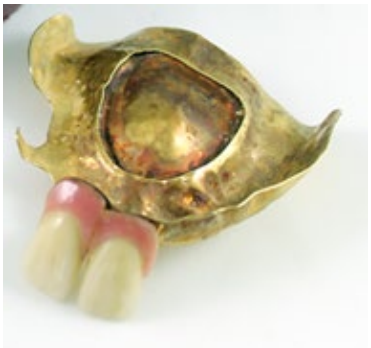
RESTORATION OF THE FACE. This method of constructing artificial dentures, combines, with great advantage, another important feature, which consists of additional attachments to the dentures for restoring the form and natural expression of the face, in cases where the muscles have become sunken, or fallen in from the loss of the teeth and consequent absorption of the alveolar processes. These attachments are so constructed as to become permanent fixtures, or component parts of the denture ; and of such form and dimensions, as to bring out each muscle or portion of the face which may have become sunken, to its original position ; and when rightly formed, cannot be detected by the closest observer. By this means, the natural form and expression of the face can be preserved through life. The necessity for these attachments arise from the fact, that there are in many instances two important points to be attained ; one is, permanence of the teeth ; the other, restoration of the features, both of which cannot be effected by simply inserting the teeth. In order that artificial teeth may be useful for masticating, they should be placed upon the plate and articulated in such a manner as to have the pressure in chewing come upon the inner rather than the outer margin of the alveolar ridges. This position of the teeth will prevent the plates from becoming dislodged from one side, while chewing upon the opposite, and secures permanence in mastication. If the teeth are placed far enough apart to restore the muscles of the face to their original fulness, they will in many cases prove useless for masticating food.

THE FACE, Is formed of different muscles, which give it shape and expression. These muscles rest upon the teeth and alveolar processes, which sustain them in their proper position. When the teeth are lost, and a consequent absorption of the alveolus takes place, the muscles fall in, or become sunken in a greater or less degree,

according to the temperament of the person. If the lymphatic predominates, the change will be but slight. If nervous sanguine, it may be very great. There are four points of the face which the mere insertion of the teeth does not always restore, viz : one upon each side, beneath the malar or cheek bone ; and one upon each side of the base of the nose, in a line towards the front portion of the malar bone. The muscles situated upon the sides of the face, and which rest upon the molar or back teeth, are the Zygomatics Major, Masseter and Buccinator. The loss of the above teeth causes these muscles to fall in. The principal muscles which form the front portion of the face and lips are the Zygomatics minor, Levator labii superioris alasque nasi and Orbicularis oris. These rest upon the front, eye, and bicuspid teeth; which, when lost, allow the muscles to sink in, thereby changing the form and expression of the mouth

The insertion of the front teeth, will, in a great measure, bring out the lips, but there are two muscles in the front portion of the face which cannot, in many cases, be thus restored to their original position ; one is the Zygomaticus minor, which arises from the front part of the malar bone, and is inserted into the upper lip above the angle of the mouth. The other is the Levator labii superior is alaeque nasi, which arises from the nasal process and from the edge of the orbit above the infraorbitar foramen. It is in serted into the ala nasi or wing of the nose and upper lip The attachments before mentioned, applied to these four points of the face, beneath the muscles just described, bring out that narrowness and sunken expression about the upper lip, and cheeks(to the same breadth and fullness, which they formerly displayed, thus restoring the original pleasing and natural expression. These attachments for restoring the form of the face were first constructed by the subscriber, some twelve years since, and they have been constantly worn by various persons with ease and comfort ever since that period.

Here, the artistic skill of the dentist is brought into



requisition. He should study the face of his patient as the artist studies his picture, for he displays his genius not upon canvas, but upon the living features of the face; and of how much more importance is the living picture, that reflects even the emotions of the heart, that the lifeless form upon canvas. He should know the origin and insertion of every muscle of which the face is formed, and what ones he is to raise, and where to apply his attachments; otherwise, he may produce distortion instead of restoration, by allowing them to underlay other muscles than those intended to be brought out If these attachments are rightly foimed and properly adapted, they cause no discomfort in wearing, or impediments in eating, speaking, or langhing. If skill and judgment have presided over all parts of the operation the result will be highly pleasing and of practical utility.

PEOPLE YOU SHOULD KNOW!

Dr. William George Allen, C.S.A.

Dr. William George Allen was born in Shreveport, La., April 12, 1846, and died at his home on Lake Washington, Miss., January 12, 1922. Enlisting as a boy in the War between the States, young Allen was first with Capt. R. N. Hall's ninety-day troops during May, June, and July, 1863, this troop being made up in Hinds County, Miss., and he was at the battle of Raymond and through the campaign to August 1, 1863. He was afterwards in R. H. Baker's company of scouts, in W. H. Jackson's Division of Cavalry, Army of Tennessee and served in the Georgia and Tennessee campaign.

Dr. Allen was an honored and beloved citizen of the Lake Washington community of Washington County, Miss., for half a century, and his life had been spent in doing good. For fifty years he had been a member of the Presbyterian Church, and in his Church relations, as in his devotion to his country, his family, and his friends, he was noted for strict fidelity. In all the relations of life as husband and father, as a citizen, a neighbor, and friend he measured up to the highest. He was a man of the highest personal honor, a gentleman of the old school, a physician of distinction, and a friend as true as steel.

Through life he clung steadfastly to his patriotic ideals, and his loyalty to the Confederate cause was marked by the unswerving interest he took in all its organizations, attending and taking part in nearly every Confederate reunion. At the time of his death he was Surgeon General of the Mississippi Division U. C. V.

Clothed in his Confederate uniform, he was laid to rest in Greenfield Cemetery, there to await the resurrection morn.

Confederate Veteran, Vol. XXX, No. 11, November 1922; p 431

WILLIAM WEIGHTMAN VALK

Chief Surgeon, *USS Constellation*, Mexican War Surgeon, 2d Maryland (Eastern Shore) Infantry, US, Surgeon, 4th Maryland Infantry, US Surgeon, 5th U.S. Veteran Volunteers

Residence was not listed;
Enlisted on 2/23/1835 as an Assistant Surgeon in the U.S. Navy. On 10/10/1838, he resigned his commission Enlisted on 10/10/1861 as a Surgeon. On 10/10/1861 he was commissioned into Field & Staff MD 2nd ES Infantry. He was Mustered Out on 10/1/1862. On 10 /16 / 1862, he was commissioned into Field & Staff MD 4th Infantry. He was mustered out on 5/31/1865 with the regiment.

William W. Valk was a U. S. Congressman, U. S. Naval Officer, and Civil War Union Army Officer. A native Southerner who would serve the United States Government faithfully, he was born in Charleston, South Carolina on 12 October 1806. He was the oldest child of Jacob Roberts and Sarah Ann Gyles Valk. He had four younger brothers and five younger sisters. On 16 July 1829, he married Jane Sherwood Farquhar Jones (1808-1854). The couple had three sons, one of whom became a doctor. William earned a medical degree in 1830 from the University of South Carolina at Columbia. Soon afterward, he established a practice in Connecticut, and 1835, he commenced a varied and adventurous life. On 23

February enlisted in the United States Navy and served as the Chief Surgeon on board the warship USS Constellation. He resigned his commission on 10 October 1838.

In 1849, he joined the thousands who migrated to California to participate in the famed Gold Rush. Like a majority of the California settlers, he failed to find his fortune there, and returned to the East, establishing a medical practice in Flushing, Queens Co., Long Island.

In 1854 he made a successful run for Congress as an American Party candidate, and was elected to represent New York's 1st District in the United States House of Representatives, serving from March 4, 1855 to March 3, 1857. In 1856 he was defeated by Democratic Congressman John Alexander Searing in his bid for re-election.

On 17 February 1857, William married Anna Gordon Sudler (30 Dec 1835-17 Apr 1913). The marriage produced six sons and four daughters

When the Civil War broke out in 1861,he was living in Chestertown, Kent Co, Maryland. He joined the Union Army on 10 October 1861,became the Chief Surgeon for the 2nd Maryland (Eastern Shore) Volunteer Infantry and was mustered out on 1 October 1862.

On 16 October 1862, he was commissioned as Surgeon in the 4th Maryland (US) Infantry. He mustered out with the regiment on 31 May 1865.

After the war he was appointed as a Pension Office Clerk, an occupation he served in from 1867 until his death in Washington, DC on 20 September 1879 from Phthisis Pulmonalis (aka Tuberculosis) He was interred in Flushing Cemetery, Queens County, NY. His first wife died in Flushing, Queens Co., New York, but it is unknown where she is buried. His second wife out lived Dr. Valk by 34 years and is buried in Rock Creek Cemetery in Washington, DC.

On his passport application in 1849, he was described as being 43 years of age and 5 feet 2 inches tall. He had a high forehead, hazel eyes, aquiline nose, small mouth, sharp chin, and brown hair.

GUNSHOT INJURIES OF THE KNEE JOINT, REQUIRING AMPUTATION. A. B. CROSBY, A. M., M. D. Professor of Surgery, DARTMOUTH COLLEGE (1864)

A good surgeon, says an old adage, should have an eagle's eye, a lion's heart, and a lady's hand. An aphorism as patent as this needs no demonstration; yet I hold it to be equally true that a good mechanic, with a reasonable knowledge of anatomy, may be a fair operative surgeon but, to affirm that such an one is a good surgeon, would be as absurd as to say that a body without brains is a perfect man.

Private Sibley, Co. H, 15th Regiment. Mass; Volunteers, was wounded on the 21st of October, 1861, in the left knee, the lower extremity of the femur being fractured. The case came under my observation some days after the engagement, and inflammation had already supervened; pus formed among the muscles of the 'thigh' and burrowed. The constitutional symptoms· were grave, and this soldier, having previously been addicted, excesses, broke down rapidly. Primary amputation was not suggested by the surgeon who first dressed the leg, and his pulse never warranted a secondary operation. His tongue became brown, dry and cracked; the pulse was rapid, and small; he was delirious; emaciation occurred rapidly; the skin grew sallow, dry and harsh; the wound was sloughy, with no sign of healing; pyaemia developed; the discharges were involuntary; and on November 5th, towards the close of the second week, this soldier died by asthenia.

An autopsy showed a round musket-ball, lodged in the lower extremity of the femur, with fracture. The external wound as small; the swelling of the knee was inconsiderable and most the pus was in the muscular interspaces of the thigh. This case was left mainly to nature, the injury apparently was insignificant yet it moved steadily on to a fatal issue.

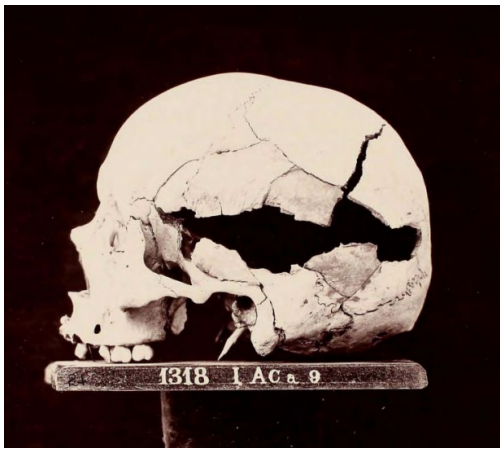
Photographic Series No 44 - Gunshot Fracture of both Parietals

Private John W. Snyder, Company B, 49th Pennsylvania Vols., was wounded by a conical musket ball, April 1, 1865; in an assault upon the trench lines at Petersburg, and was admitted to Judiciary Square Hospital, at Washington, April 12th, 1865. On admission, he had dilated pupils, a slow pulse of 56 per minute, restlessness, and stupor. He could be aroused to consciousness. There was no paralysis. On April 13th, a fragment of bone was 3/4th of an inch square was removed and the symptoms of compression of the brain gradually subsided. During his convalescence, it was noticed that his vision was impaired. This was especially on the left side. On June 13, the wound had cicatrized except at one-minute point. It is possible that there was communication with a small-necrosed fragment of bone.

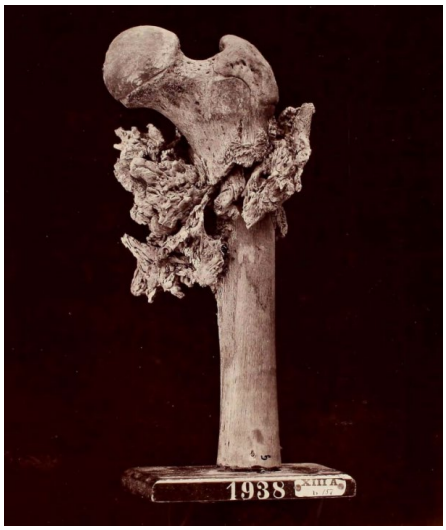
PHOTOGRAPH No. 31. Left Femur, exhibiting a partly consolidated Gunshot Fracture of the Middle Third of the Shaft. Corporal II. Burns, Co. II, 31st New York Volunteers, was struck by a conoidal musket ball at the battle of Chancellorsville, May 3, 1863. The missile fractured the shaft of the left femur, with the unusual longitudinal splintering. On May 8th, the patient was admitted to Douglas Hospital at Washington, and it was decided to attempt to save the limb. The limb was first suspended by Smith's anterior splint. Afterwards Hodgen's apparatus was applied, and apparently answered a better purpose but large abscesses having formed in the thigh, and free incisions becoming becoming requisite, a long fracture box, filled with bran, was substituted. On June 16, 1863, the ball and several fragments of detached bone were removed. The patient. died on July 11, 1863, from exhaustive suppuration. Several days before his death, gangrenous patches appeared on the left leg. The preparation shows well the extent of the fracture and of the reparative process. There are several sequestra enclosed in the large deposit of callus. The specimen, and the facts concerning it, were contributed by Assistant Surgeon William Thomson , U. S. Army.

PHOTOGRAPH No. 25. Fourth, Fifth, and a portion of the Sixth Dorsal Vertebrae, sawn asunder to show the Point of a Knife blade, which, passing between the Transverse Processes of the Fourth and Fifth Vertebrae, and traversing the Vertebral Canal, has entered the body of the Fifth Vertebra.

Private George Sweeney, Co. B, 15th New York Engineer Regiment., in an altercation with a comrade, was stabbed in the back with a dirk, at Falmouth, Virginia, the 20th of April, 1863. He was admitted to Armory Square Hospital, at Washington, on April 22d, completely paraplegic. On April 27th, he began to pass his feces and urine involuntarily, and bed-sores appeared on the portions of the lower part of the body exposed to pressure. He sank very slowly, dying from exhaustion on May 27, 1863. The specimen was contributed by Assistant Surgeon C. C. Byrne, U. S. Army.



PHOTOGRAPH No. 21. Skull, exhibiting an extensive Fracture from Grape-shot. The Missile entered the Left Parietal Bone near the Lambdoidal Suture, and emerged through the Squamous portion of the Temporal Bone.
The specimen was picked up by Surgeon Frederick Wolfe, 39th New York Vols., in June, 1863, under an abatis near the stone bridge over Bull Run, and is supposed to be the cranium of a confederate soldier, killed in the second battle of Manassas, August, 1862, At that action a portion of Longstreet's Corps charged upon one of the federal batteries in position near this locality.
‘



PHOTOGRAPH No.5. Left Femur· of a Confederate Soldier, exhibiting Attempts at Repair of a Gunshot Fracture of the Upper Third.

Private E. W. A " Co. G, 5th Florida Regiment, 18 years of age, was wounded July 3d, 1863, at the battle of Gettysburg, by a conoidal musket ball, which shattered the upper third of the left femur. He was first treated in a field hospital, but on August 5th, 1863, was admitted to Camp Letterman General Hospital. At that date, the patient was reduced by profuse suppuration: he was greatly emaciated, and large bed-sores had formed on his back. On August 12th, a troublesome diarrhoea set in. He lingered till September 15th, 1863, when he died from exhaustion. The large foliaceous masses of callus uniting the fragments are extremely delicate and brittle. The Specimen is numbered 1938 in the Surgical Section of the Museum.

DOMESTIC MEDICINE CHESTS OFTEN BELIEVED TO HOLD SUPPLIES FOR TRAVELLING PHYSICIANS, IN MOST CASES MEDICINE CHESTS WERE INTENDED FOR DOMESTIC OR PERSONAL USE

History
Archaeological evidence shows that the Egyptians and the Romans had specific containers for domestic medical supplies.

From the 1500s, naval and army surgeons’ needs prompted the development of large medicine chests and wealthy noblemen took luxurious medicine chests on their travels. The fashionable Grand Tour increased the need for portable medical supplies.

Even though there was a long tradition of self-medication in Britain, domestic medicine chests only arrived here in the late 1700s, reaching the height of their popularity in the mid 1800s. An increase in specially-supplied chemical remedies and ready-made powders and tinctures provided many of the contents, and the growth of middle class prosperity, with consumer goods as the basis of the Industrial Revolution, meant that there were plenty of potential customers.

The chests

Cabinet makers, used to creating tea caddies and writing slopes, applied their craftsmanship to medicine chests. Frustratingly, they rarely printed their names on their products. Retail and wholesale druggists or apothecaries bought the chests and in many cases fitted them out fully. In 1808, Richard Reece's range included a Family Dispensary, Clergyman's Dispensary and a Tropical Dispensary. Chests were also fitted out to customers' specifications, meaning that the contents of surviving chests vary.

A chest's style gives some idea of its date. The earliest British chests were covered in fish skin. In the late 1700s, oak and walnut chests were popular. Mahogany, rosewood and walnut were fashionable in the 1800s. The most popular lifting lid style dates from the late 1700s, and became fashionable again in the mid to late 1800s. Small details, like handles, can also give clues. From the 1820s, military style flush brass handles were in fashion.

The knowledge

Medicine chests were used alongside manuals written for the lay public. Twenty titles were published in Britain between the 1760s and 1890s, and each ran to many editions. Copies of these books are now quite scarce. They were practical guidebooks containing lists of the chest's contents and how to use them, detailed explanations of weights and measures, tables relating dosages to a patient's age, instructions for purging, emetics, bleeding, and also first aid directions for resuscitating after poisoning or drowning. All recommended access to a qualified physician.

The contents

Medicine chests' contents provide an insight into treatments being used in the middle-class home. They tend to reflect this era of "heroic medicine" with vigorous therapies and chemical remedies, such as Dr James' Fever Powders, containing poisonous antimony, which were common to treat fevers. Medicines and equipment for purging, enemas, emetics, blistering, and blood-letting were typical. Common contents included turkey rhubarb as a stomachic, astringent and purgative, tincture of jalap, a strong purgative, and ipecacuanha as an emetic and expectorant. The only painkillers available were opium-based, usually as laudanam or tincture of opium. However, chests with homeopathic contents were also introduced alongside allopathic ones.

From the late 1700s, a chest's bottles were square or rectangular in section. Empty ones were re-filled and sometimes re-labelled by a pharmacist. The labels were usually on their shoulders so they could be read from above when placed in the chest. Most chest designs also included drawers. Early ones often had sliding covers, fitted tin boxes, and a rack to hold

glass jars with parchment or chamois tie-on covers. Later, drawers also contained powders in individual paper packets.

The accessories in chests became very standardised. They usually included:

• A hand-held balance and weights, usually based on the Apothecary's Troy system. The design of the weights can give some clue to their date.

• A lancet for lancing boils and abscesses. However, blood-letting, lancing or minor operations were not recommended by the manuals unless by a professional.

• A marble or ceramic tile, a spatula and a mortar & pestle for preparing and mixing ingredients.

• A Seidlitz measure, for two powders (collectively called a Seidlitz Powder) which were dissolved in water as a treatment for indigestion.

• A funnel, used to refill bottles. This was silver or pewter in earlier chests, glass in later ones.

• Blistering items – a blistering plaister (or plaster) was gently heated, spread on linen or cotton with a plaster iron, and applied to the skin. The resulting blister was believed to "move" existing pain, as a "counter irritant."

• A probang – a long flexible device used to dislodge anything stuck in the gullet.

• Curved glass leech tubes – to direct a leech's attention to problem areas like a gumboil.

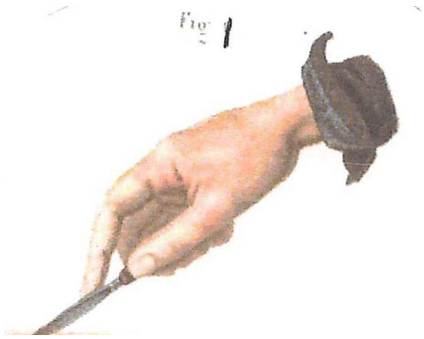
• Caustic stick in a case – silver nitrate used to burn

The decline in medicine chests has been explained by the growth of available supplies and advice from hospitals, pharmacies, and doctors, public health improvements that meant less epidemics and hygiene-related illnesses, and changes in the preparation format of medicines with a greater use of tablets. Medicine chests continued to be made and sold into the early 1900s. But today, the bathroom cabinet, and the first aid kit have replaced the medicine chest as our source of immediate domestic medical supplies.

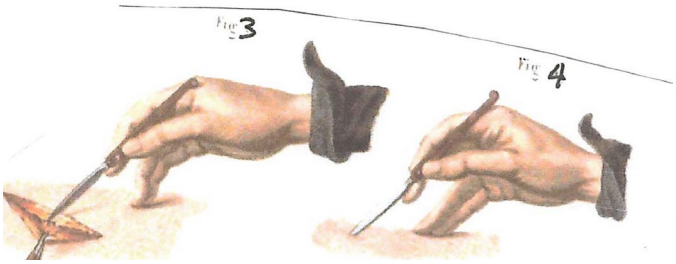
Taken from the MUSEUM OF THE ROYAL PHARMACEUTICAL SOCIETY 1 Lambeth High Street, London SE1 7JN INFORMATION SHEET # 16

METHODS OF HOLDING THE BISTOURY

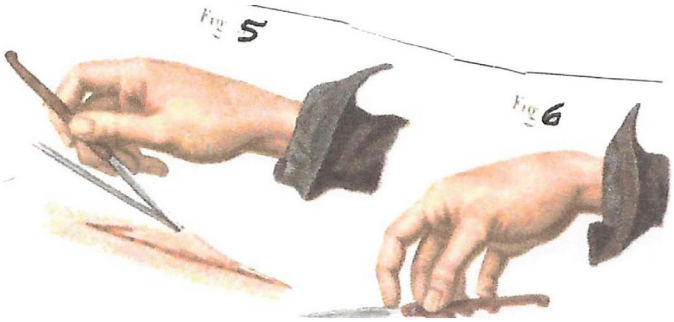
The positions in which the bistoury may be held are liable to infinite variety; nevertheless, for the purposes of operative surgery, these positions, may be reduced to three, and each of them subdivided into two varieties.



First Position (fig. 1 and 2). The handle of the bistoury is held firmly in the whole hand, like a table knife. In this position, the end of the handle of the instrument always rests in the palm of the hand, whilst the cutting edge may be turned either downwards (as in fig. 1), when the index finger is extended upon the back of the blade; or upwards (as in fig. 2), when the index is placed near the junction or the blade with the handle, and on its side.



Second Position (fig. 3 and 4). The bistoury held like a pen in writing, the cutting edge being turned downwards (fig. 3) or upwards (fig.4).
This position of the instrument is suitable when we desire its movements to be at the same time delicate and precise.



Third Position (fig. 5 and 6). The bistoury is held like, the bow of a violin. In one of the varieties of this position, the point of the instrument is carried forward with its edge downwards (fig. 6); in the other the point is carried backwards, with the edge upwards (fig. 6). This position is employed when we wish to use the knife with the utmost delicacy and prudence.

Taken from the Illustrated Manual of Operative Surgery and Surgical Anatomy by C.L. Bernard, MD and C.H. Huette, MD 1864 (Available free on Google Books)

Catherine S. Lawrence: The World's First Nurse Anesthetist?

Over the years, many CRNAs have wanted to learn the identity of the world's first nurse anesthetist. In 1941, Agatha Hodgins wrote that, "while we would like to know with certainty the name of the first nurse anesthetist, so that we

might give her prior honor, we reluctantly admit that there remains a veil of mystery over this lady."1 Historian Virginia Thatcher' concluded that in all likelihood the first nurse anesthetist was the Catholic nun, Sister Mary Bernard, who in 1877 "entered St. Vincent's Hospital in Erie, Pa., to take up nursing and within one year was called upon to assume the duties of anesthetist." Thatcher and Marianne Bankert wondered if there were nurse anesthetists before Sister Mary Bernard who went unrecorded and were therefore lost to history. We will probably never be able to prove beyond doubt who the first nurse anesthetist was, but as more records come to light we may discover earlier and earlier practitioners.

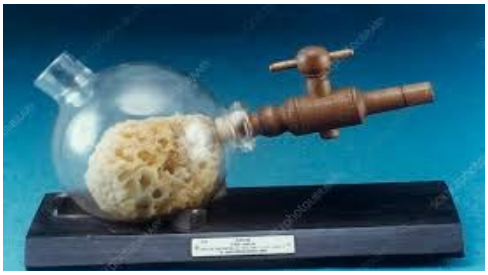
It is well known that nurse anesthetists proved their capabilities and thereby advanced themselves and their profession during the wars of the 20th century. World War I is perhaps the best-known example. In view of the extreme demands and the confusing nature of wartime surgery, it has always seemed likely to me that nurses were called upon to administer anesthesia during the wars of the 19th century as well. During the Civil War the unprepared and understaffed Union and Confederate medical corps were overwhelmed by injuries, poor sanitation, malnutrition, and disease. Surgery was still dangerous and often fatal owing to the lack of asepsis, the relative unavailability of anesthesia, and the inexpert way in which anesthesia was administered. One Civil War nurse described chloroform administration in her journal as "deliberate murder."' Professional nursing was in its infancy during the Civil War, and until now I have never read of a Civil War nurse being called into duty

as an anesthetist.

In the spring of 1999, Lt. Brenda Finnicum, CRNA, AN, USA, who was at the time stationed at West Point, N.Y., told me in a telephone call about a driving trip she and her husband had recently made through central New York State and a visit to the Old Stone Fort Museum in Schoharie County. It was there that her husband noticed a display case that contained a picture and some items related to Catherine S. "Kate" Lawrence, who was a Civil War nurse. We are very much indebted to Brenda's husband for this observation and to Brenda who brought it to light. For Catherine S. Lawrence, at the urging of her friends and in order to supplement her $12 per month pension from the government, wrote an autobiography late in life in which she claimed to have administered chloroform at the Second Battle of Bull Run.

Could Catherine be the world's first nurse anesthetist? If so, our history would be backdated another 14 years, and our already strong affiliation with nurses in the military would be cemented further.

Soon after the outbreak of the Civil War thousands of women joined the Union and Confederate armies. By one estimate is that 20,000 women volunteered and/or served officially. The vast majority of women who entered the Civil War became nurses and created for themselves an invaluable role as the superintendents of army hospitals. Accounts of women's Civil War experiences exist in diaries, biographies, and histories. For the most part, nurses wrote of securing food and other supplies, supervising diets and medications, changing dressings, and providing wounded and dying soldiers with spiritual comfort. On rare occasions, they also assisted surgeons. In their diaries, nurses described their hectic and heroic existence, working countless



hours during and after a battle and then nursing dying soldiers, often for as long as several weeks until death came. I have read many first-hand accounts written by Civil War nurses and never found any evidence that a nurse's comforting role was ever extended to administering anesthesia.

Then I read an autobiography entitled Sketch of Life and Labors of Miss Catherine S. Lawrence.
Catherine Lawrence, a retired Army nurse, wrote her autobiography late in life, in which she claimed to have administered chloroform at the Second Battle of Bull Run. Here is Catherine's description of events leading up to and following the battle:
"The [hospital] rooms were nicely finished, with hot and cold water and gaslight…There were 25 beds on either side of the center aisle… All things were ready to receive patients, and we were not long kept waiting … Every train brought some sick but more wounded ... this lasted over two days. The worst cases were retained, the less serious being sent to other hospitals. Our wards were filled. Mine was an amputating ward...My duties are quite numerous. There were 10 patients whose wounds I had to dress. The worst cases of the wounded the doctor would attend to. Reflecting on her experiences, Catherine wrote on the very next page: "I rejoice that our American nurses are being trained for positions so important. A skillful nurse is as important as a skillful physician. Life has too often been sacrificed by both professions."

Catherine S. Lawrence, who lived from 1820 to 1904, was born and raised in Schoharie, N.Y. She was a small, but strong-willed and outspoken person who credited her strength to a distant relative who had captained a ship in the War of 1812. Whenever she faced a challenge, she wrote, "Lawrence cannot give up the ship." At the age of 14, Catherine's parents died, forcing Catherine to support herself as a seamstress until she received enough education to become a teacher. When she left Schoharie a few years later, Catherine embarked upon life as a crusader for human rights and social reform. She wrote that, "I fully believed in the rights of women to speak and pray in public." Catherine traveled widely, speaking in churches and schools throughout New York and neighboring states about religious

obedience, temperance, and the abolition of slavery Audiences must have received Catherine well, for she was often asked to return.

Although Catherine was a religious person, she was not bound to any one church. She had Methodist, Calvinist, Baptist, and Reform connections, but insistently wrote: "My religious sentiments were always found where I could do the most good ..." She held herself and others to very high standards. When the war came, it must have been an easy decision for her to enlist. We know that she served in Union hospitals around Washington, D.C., and that after the war she adopted three orphaned siblings. Catherine is buried in her family's plot at the Old Stone Fort Cemetery in Schoharie beneath a stone that reads simply "Catherine S."

Everything we know about Catherine Lawrence comes from her autobiography. But we want to know more. Possible sources of information include Army muster rolls, hospital records, and New York historical societies. Perhaps the veil of secrecy surrounding the identity of the first nurse anesthetist has finally been drawn aside.

Taken from the AANA News Bulletin/December 2001. For further reading see: Lawrence C. S. Autobiography: Sketch of Life and Labors of Miss Catherine S. Lawrence. Albany, NY: James B. Lyon: 1896

REPORT INTERESTING SURGICAL OPERATIONS, PERFORMED AT THE U. S. A. GENERAL HOSPITAL, BEVERLY, NEW JERSEY. C. WAGNER, ASS'T SURGEON U. S. A. COMMANDING HOSPITAL (1864)

During the past five or six months many interesting capital operations have been performed at the hospital under my charge, by my assistants and myself. August and September brought us a large number of cases of frightful wounds received at the battle of Deep Bottom, Va., and in the numerous engagements before Petersburg, the worst cases I have ever seen off the field of battle.

CASE OF RESECTION OF HEAD OF FEMUR.

Pvt. John Zabrouski, Co. K, 7th Conn. Vols., was wounded at the battle of Deep Bottom, Va., by a minnie ball, which fractured the head and neck of the femur. He was admitted into hospital on the 22d of August. On the 27th of September a resection of the head of the femur was decided upon. He had greatly lost in flesh and strength since his admission, and seemed to be rapidly failing from the exhaustive suppurative discharge from the wound; extensive sloughing of the soft parts had supervened, and, upon the whole, the case was unfavorable and unpromising for so important an operation. Chloroform was administered, the patient placed upon his sound side, an incision four-and-a-half inches in length, extending from about two-thirds of an inch below the anterior superior spinous process of the ilium, towards the tuberosity of the ischium, crossing a transverse incision which had previously been made over the trochanter major to permit of a free exit of pus. The thigh was flexed and rotated inwards, the tendons of the muscles divided, and the chain saw passed under and between the head of the femur and the trochanter major, and the bone sawn through the neck, the soft parts being protected by spatulas; one inch of the trochanter major was removed by a small saw; no blood was lost. The patient survived the operation only thirty hours, dying from exhaustion. A post mortem examination revealed nothing worthy of note except slight necrosis of the acetabulum.

The following case of successful amputation at the hip joint is deserving of special mention. The sufferer has been operated upon six times, and still lives. To the surgical skill, and the kind and unremitting attention on the part of Dr. J. C. Morton, Executive Officer of the Hospital, the successful result is mainly due: Eben E. Smith, private, Co. A, 11th Maine, single, aged 19, was admitted into U. S. A. General Hospital, Beverly, N. J., August 22, 1864, suffering from gunshot wound of right leg, received August 16, 1864, in the battle of Deep Bottom, Va. The ball passed from before backward, fracturing head of the tibia. When admitted he suffered but little pain, although the Joint was considerably swollen.

Sept. 12, 1864, secondary hemorrhage occurred. A careful examination was made, and it was deemed advisable to amputate, which operation was performed by the circular method, at the lower third of the thigh.

Chloroform was administered, the patient reacted promptly. The patient did well until October 17, 1864, when secondary hemorrhage occurred from the stump, at which time the femoral artery was ligatured in Scarpa's space, the ligature separated October 27. November 5, end of femur protruding, about four inches of which was removed by the chain saw.

Shortly after, the stump became swollen and abscesses began frequently to form. This state of things continued until Jan. 19, when, upon examination, the bone was found to be necrosed up to the trochanters. Amputation at the hip joint was deemed advisable, and performed by antero-posterior flaps.

January 27, hemorrhage again occurred from the stump, when the external iliac artery was ligatured. Feb. 17, the ligature separated. Feb. 19, profuse hemorrhage occurred from the lower end of the divided artery, and was controlled with great difficulty, owing to the many operations previously performed; pressure was maintained some fourteen days, after which the patient rapidly improved, and has now entirely recovered, (March 31, 1865.)

John Williams, private, Co. F, 13th Ohio, married, aged 44, was admitted into U. S. A. General Hospital, Beverly, N. J., October 7, 1864, suffering from gun shot wound of the left thigh, middle third, with partial fracture of femur; wound received Sept. 30, before Petersburg, Va.

His general condition Continued favorable until Feb. 1, when abscesses began to form in the upper part of the thigh, which discharged a large amount putrid pus; at the same time the patient was attacked with a severe diarrhoea.

Feb. 17, an examination was made and the femur was found necrosed as high as the trochanters. Amputation at the hip joint was considered the patient's only chance for life, and performed by antero-posterior flaps. The femoral artery was caught and vied as soon as divided, and before completing the amputation, by which but very little blood was lost. The patient reacted slowly for about twenty-four hours, when he began to sink, and died twenty-nine hours after the operation. An autopsy revealed nothing worthy of special mention.

After receiving their wounds, many of them neces-sarily failed to obtain either proper food or care upon the field of battle. As a result, they did not compare favorably with similar operations performed under more fortunate circumstances with better treatment of the wounded.

The preceding report includes nearly all the capital operations that were performed at this Hospital, from the latter part of August, 1864, to March 1st, 1865. A large number of minor operations, such as removal of fingers, toes, etc. were considered of not sufficient interest to report.

CHILDREN TEETHING FROM DR GUNN'S BOOK DOMESTIC MEDICINE OR THE POOR MAN'S FRIEND: THE LATEST & MOST APPROVED MEANS USED IN THEIR CURES -1860 (Google Books)

The treatment during teething, should be a particular attention to the bowels, by keeping them sufficiently open; always paying close attention to every circumstance likely to promote the general health of the child, such as pure air, exercise, strict cleanliness, food easily digested in the stomach, and taken in small quantities. As the difficulties sometimes are greatly lessened and frequently entirely prevented by looseness coming on spontaneously or more plainly speaking, its own accord. It must not be checked, particularly in children of a fat or full habit, but permitted to go, on unless it weakens the infant too much or runs to excess, when it may be stopped by degrees. It should take some laxative purge…two grains calomel, to which add three or four grains of rhubarb or magnesia.

ANNOUNCING THE 9TH ANNUAL GATHERING OF THE SOCIETY OF CIVIL WAR SURGEONS

ATLANTA, GEORGIA

It is our distinct pleasure to invite you to attend The Society of Civil War Surgeons Annual Gathering (Conference) for **March 28-29-30, 2025.**

The Gathering will offer the participants dynamic sessions on historical medicine with experts in the Medical field. The Gathering will also provide a major opportunity for exchanges between representatives of different specialties with the medical community in this transitional period in American Medicine.

The Society of Civil War Surgeons is open to anyone interested in any aspect of Civil War era medicine. We have Civil War Roundtable members, museum personnel, historians, researchers, historic site personnel, collectors, lecturers, as well as medical reenactors. The Society continues to play an important national leadership role in promoting education and dissemination of knowledge since 1980.

The Goal of the Society is to promote a deep and abiding appreciation for the rich medical heritage of the American Civil War. We are a 501(c) 3 not-for-profit educational corporation. We support learning and understanding of the past in context with the medicine of the present and future.

The gathering will start on Friday, March 28, 2023 with a visitation to the Atlanta History Center, Atlanta Cyclorama Painting of the Battle of Atlanta, a tour of the Kennesaw Mt. Battlefield, and at least one more location.

Saturday, March 29, 2025 the group will have up to six presentations on Civil War Medicine.

Sunday, March 30, 2025, three additional presentations will be provided between 8:30 am and the close of the Gathering at 12 noon.

The cost of the Gathering is $135.00 per person for members and $170.00 for non-members (includes a one-year membership in The Society). This conference includes all lectures, tours, and lite snacks during the conference sessions.

Our Gathering Hotel is not yet set. We will send all current members information in Mid-April 2024. **Members are encourages to sign up early as there will be limited spaces at the Gathering.**

NEW MARKET LIVING HISTORY WEEKEND
VMI - VIRGINIA MUSEUM OF THE CIVIL WAR
MAY 16-17-18-19, 2024

Society of Civil War Surgeons
"Hallowed Ground Medical Living History Event"

Tentative Schedule:
We will set up Thursday, May 16, 2024

Demonstrations and Living History for the Public on:
Friday, May 17, 2024
Saturday, May 18, 2024
Sunday, May 19, 2024

This is the "Official Weekend" for Virginia Military Institute to remember the **"160th Field of Lost Shoes"** Cadets.

WE ARE TAKING REGISTRATION FORMS NOW UNTIL APRIL 1, 2024

2024 Society of Civil War Surgeons
Living History Weekend
NEW MARKET LIVING HISTORY WEEKEND
VMI - VIRGINIA MUSEUM OF THE CIVIL WAR
MAY 16-17-18-19, 2024
Hosted by The Society of Civil War Surgeons and VMI

*****Please Print*** ***Please Print*** ***Please Print*****

Name:_____

Address:_____

City/State/Zip: _____

Home Phone: _____ Fax: _____

Email address:_____

Tent Size/Type: _____Unit:_____

Portrayal: (IE surgeon, hospital steward, patient, nurse, civilian, etc.)_____

Please check: Military _____ Civilian _____

REGISTRATION ENDS April 1 2024: NO WALK-ONS. SUBSTITUTIONS WILL BE PERMITTED ONLY WITH PRIOR APPROVAL OF THE SOCIETY COORDINATOR!

Pre-registration is open to anyone 14 and over. Anyone under the age of 14 must obtain event committee approval for participation.

As an event participant, I will abide by the rules and regulations of the Society of Civil War Surgeons for Hallowed Ground Living History Events. I will follow the order of the Society coordinator as well as any instructions given to me by a VMI Museum staff member or authorized representative.

I hereby agree to abide by the rules and regulations, to follow the instructions of the Society Coordinator and to fully cooperate with event hosts.

_____

Authorized Signature Rank

Mail to: **Trevor Steinbach, President**
The Society of Civil War Surgeons
129 Lively Stream Way
Gettysburg, PA 17325-6022

2024 Society of Civil War Surgeons Living History Weekend

Spangler Farm, Gettysburg, Pa

August 1-2-3-4, 2024
Hosted by The Society of Civil War Surgeons &
The Gettysburg Foundation

The Society Gettysburg Weekend has been set.
We will be at Spangler Farm again this year!

Set up will begin on Thursday, August 1st at 1:00 pm EST.

We will greet the public on
Friday, August 2, 2024
Saturday, August 3, 2024
Sunday, August 4, 2024.

During the hours of 10:00 am & 3:30 pm

This will be a Society members-only event.
You must be a current 2024 paid member to participate.

REGISTRATION CLOSES: JULY 15, 2024

2024 Society of Civil War Surgeons
Living History Weekend
Spangler Farm, Gettysburg, Pa
August 1-4, 2024
Hosted by Society of Civil War Surgeons & the Gettysburg Foundation

*****Please Print*** ***Please Print*** ***Please Print*****

Name:_____

Address:_____

City/State/Zip: _____

Home Phone: _____ Fax: _____

Email address:_____

Tent Size/Type: _____Unit:_____

Portrayal: (IE surgeon, hospital steward, patient, nurse, civilian, etc.)_____

Please check: Military _____ Civilian _____

REGISTRATION ENDS JULY 15 2024: NO WALK-ONS. SUBSTITUTIONS WILL BE PERMITTED ONLY WITH PRIOR APPROVAL OF THE SOCIETY COORDINATOR!

Pre-registration is open to anyone 14 and over. Anyone under the age of 14 must obtain event committee approval for participation.

As an event participant, I will abide by the rules and regulations of the Society of Civil War Surgeons for Hallowed Ground Living History Events. I will follow the order of the Society coordinator as well as any instructions given to me by a Gettysburg Foundation staff member or authorized representative.

I hereby agree to abide by the rules and regulations, to follow the instructions of the Society Coordinator and to fully cooperate with event hosts.

_____

Authorized Signature Rank

Mail to: **Trevor Steinbach, President**
The Society of Civil War Surgeons
129 Lively Stream Way
Gettysburg, PA 17325-6022