PROCEEDINGS OF THE LOCAL BRANCHES

"All papers presented to the Association and Branches shall become the property of the Association with the understanding that they are not to be published in any other publication prior to their publication in those of the Association, except with the consent of the Council." —Part of Chapter VI, Article VI of the By-Laws.

ARTICLE III of Chapter VII reads: "The objects and aims of local branches of this Association shall be the same as set forth in ARTICLE I of the Constitution of this body, *and the acts of local branches shall in no way commit or bind this Association, and can only serve as recommendations to it.* And no local branch shall enact any article of Constitution or By-Law to conflict with the Constitution or By-Laws of this Association."

ARTICLE IV of Chapter VII reads: "Each local branch having not less than 50 dues-paid members of the Association, holding not less than six meetings annually with an attendance of not less than 9 members at each meeting, and the proceedings of which shall have been submitted to the JOURNAL for publication, may elect one representative to the House of Delegates."

Reports of the meeting of the Local Branches shall be mailed to the Editor on the day following the meeting, if possible. Minutes should be typewritten with wide spaces between the lines. Care should be taken to give proper names correctly and manuscript should be signed by the reporter.

DETROIT.

The November meeting of the Detroit Branch of the AMERICAN PHARMACEUTICAL ASSOCIATION was held in the Y. M. C. A. Building, Thursday evening, November 19, 1931. Dinner was served at 6:30.

The meeting was called to order by President James Liddell at 7:30 P.M. The minutes of the previous meeting were read by the secretary and approved. The speaker of the evening, Dr. Edward Lyons, Research Chemist of Parke, Davis & Co., was introduced by Dean Lakey. Dr. Lyons presented a very interesting talk entitled "Man's Struggle with Disease;" he told of the many advances made in medicine in the last 6000 years. The most noteworthy feature of Dr. Lyons' talk was the rapid advances made in medicine during the last fifty years. Considerable discussion followed as to whether medicine has kept up with the increase in population. The speaker did not think it had; he compared the health of the world when the population was four to five million to the present population of 9,750,000,000.

Dean Kraus said, sixty years ago medical education was a disgrace, progress has been made mostly during the last thirty years. He also believed pharmacy students of to-day have opportunities never before possible. Dean Lakey and Dr. Seltzer also defended the present-day status of pharmacy and medicine.

On motion of Dr. Seltzer a rising vote of thanks was given Dr. Lyons for his interesting talk.

DECEMBER.

The December meeting of the Detroit Branch of the AMERICAN PHARMACEUTICAL ASSOCIATION was held in the Y. M. C. A. Building, Thursday, December 17, 1931. A fine steak dinner preceded the meeting. President Liddell called the meeting to order at 7:45 P.M. The minutes of the previous meeting were read and approved.

President Liddell introduced the speaker of the evening, Norval B. Fast, a registered pharmacist and law student in Detroit. Mr. Fast presented a very interesting paper entitled "We Sign on the Dotted Line." He emphasized the care necessary before signing papers, and discussed contracts as they apply to the retail druggists.

A general discussion followed, led by Professor Crandall which brought out many interesting points of value to the pharmacist. Henry "Santa Claus" Reinhold entered at this time garbed in real Santa Claus attire and loaded down with a bag full of gifts for each member attending the meeting. Each package was neatly wrapped in holly paper and marked with a sticker, "Do Not Open until Christmas." One lady was seen to leave the meeting with an unopened package. Santa Claus left wishing the members of the Detroit Branch a "Merry Christmas."

A rising vote of thanks was given the speaker.

President Liddell thanked Santa Claus and Parke, Davis & Co. for not forgetting the Detroit Branch.

BERNARD A. BIALK, *Secretary.*

NEW YORK.

The December meeting of the New York Branch of the AMERICAN PHARMACEUTICAL ASSOCIATION was held, by the invitation of the Kings County Pharmaceutical Association, at their college, the Brooklyn College of Pharmacy of Long Island University, on Monday, the 14th, President Fischelis taking the chair. There was an attendance of about 145.

The president expressed the thanks of the Branch for the kind invitation extended and for the special program that had been arranged for the evening by the Kings County Society.

The minutes of the November meeting were read by the secretary and approved. Treasurer Currens' report was read and accepted.

Mr. Lehman, Chairman of the Committee on Education and Legislation, reported that the Capper-Kelly Fair Trade Bill would be introduced into this session of Congress. He suggested that all present should write to Senator Wagner of New York, a member of the Committee on Foreign and Domestic Commerce, to request him to report favorably upon the bill.

The secretary submitted the applications of Anton Hogstad, Jr., and Sidney Beckerman for membership in the Branch; these were approved.

The president reported on the presentation of the Remington Medal to Professor E. Fullerton Cook at a Testimonial Dinner held in Philadelphia on Monday, November 16th, saying that over 150 people were present, a large number attending from New York and many coming from Baltimore and other cities. He said that it had been a delightful occasion and that he felt that such a joint undertaking did much to promote good fellowship between the Branches taking part.

The program that had been arranged for the evening was entitled "First Aid Care by the Pharmacist" and President Fischelis introduced, as the first speaker, Dr. Frederick Schroeder, Professor of Toxicology, Brooklyn College of Pharmacy, and Assistant Clinical Professor of Medicine, Long Island College of Medicine, who read the following paper on—

MEDICAL EMERGENCIES.

"The object of this paper is to bring to your attention some of the common, sudden, everyday medical emergencies that are part of the active life of a pharmacist. No attempt will be made to suggest remedial measures other than those that come within the meaning of the term first-aid. Some of the important symptoms will be discussed briefly in order that you may realize their seriousness.

"Though medical emergencies are not as numerous as those of the accidental or surgical types, and bearing in mind that the dividing line between what is medical or surgical cannot be too closely drawn, there are certain alarming conditions that are distinctly medical in nature.

"As a first-aider your duties and limitations are definitely those of any other first-aider. The exception to this rule is in cases of acute poisoning where your knowledge of poisonous drugs and their antedotes gives you a decided advantage over others who render ordinary first aid.

"Let us consider first what constitutes first aid. What are the limitations and what are the things not to be done? The following seven rules offer a safe procedure and can bring no criticism to those who assume responsibility in emergency cases.

1. The application of the manual method of artificial respiration to non-breathing patients
2. The application of antiseptics
3. The bandaging of wounds
4. The control of hemorrhage
5. The administration of certain stimulants when clearly indicated to be necessary
6. The giving of antidotes in cases of acute poisoning and the administration of emetics to remove the poison from the stomach
7. Keeping the patient warm and comfortable until the arrival of the doctor, who should be sent for immediately.

To the contrary, the following are the things that must not be done:

1. Never suture a wound
2. Never use any surgical instruments, such as forceps, knives or scissors
3. Never set a fracture
4. Never reduce a dislocation
5. Never use a hypodermic syringe
6. Never introduce a stomach tube or pump to evacuate the contents of the stomach in acute poisoning
7. Never remove foreign bodies from the eyes
8. Never move a patient without a doctor's orders unless it is impossible to get medical services for a considerable time.

"Success in the treatment of any emergency case depends entirely upon the correct diagnosis. In the accidental kinds the difficulty is not nearly so great as in those of obscure

medical origin. A person may, from all appearances, be in perfect health and without warning suddenly become violently ill. It is here where the good judgment and intelligence of the first-aider is called upon to make a diagnosis. He must be observant, tactful and resourceful. He must have some knowledge of symptoms and signs. He must endeavor to get a history regarding the patient's past and recent illnesses. The opinion formed at the first glance is often of great diagnostic value. If possible, friends, relatives or bystanders should be interrogated to obtain some clew as to the probable nature of the illness. This is most essential when the patient is unconscious.

"Symptoms are merely evidences that something has gone wrong. They may be subjective or objective in character; the former is obtained from the patient and the latter is what we are able to observe. If we are fortunate enough in getting the story from the patient it may be of great usefulness in making a tentative diagnosis. But if the patient is unconscious we have to depend entirely upon the objective symptoms. Always note the color, pulse rate, respiratory rate and pupillary reaction. Also note the breathing, whether present or absent, the evidence of bleeding, signs of shock, pulse rate, fractured bones or unconsciousness.

"The first-aider should know the significance and importance of the various signs and symptoms. With this in mind let us consider a few of the outstanding ones, such as pain, dyspnoea, vomiting, unconsciousness.

"Pain anywhere in the body is always a danger signal. It is beneficent and if we keep this in mind we will not make undue haste to abolish it, as it is nature's method of informing us that something is wrong. It indicates some morbid process and is one of the most valuable of diagnostic aids. There are times, however, when pain may be an unreliable symptom. It may lead to error in diagnosis. The type of patient, his psychic state, his surroundings, all modify this symptom. The tendency to exaggerate pain is most marked in neurotic individuals, while in the phlegmatic type, the aged, and those accustomed to hardships we find the reverse true. We must beware of the malingerer and hysteric.

"Objectively we can learn much from the facial expression. The drawn face, the clenched jaws, the dilated pupils, the livid countenance, all make a picture of agony. Also the attitude or posture in certain conditions is quite characteristic, namely: the sudden fixity in heart-pang, the crouching attitude in colic; the flecked thighs and immobile trunk in peritonitis.

"Certain fundamental principles must be perfectly understood in regard to the treatment to be instituted, for that is our first thought when we see someone suffering. The tendency is to give an opiate immediately. This, of course, should never be done for fear of masking the symptoms and, on the arrival of the doctor, cause delay in making a prompt and correct diagnosis.

"Another unforgivable piece of meddling is the administration of a cathartic for abdominal pain. Under no circumstances must this be done and let it be a cardinal rule in all abdominal complaints to avoid opiates and cathartics until the real cause of the ailment is determined by a physician. A ruptured appendix, perforated peptic ulcer, strangulated hernia, intestinal obstruction, intussusception in children, are all possibilities and causes of abdominal pain. A cathartic in such conditions would do untold harm and might even terminate the life of the patient.

"It would not be amiss here to quote from an article in a recent issue of the *Weekly Bulletin* of the Department of Health of the City of New York relative to appendicitis and the administration of cathartics. This article was taken from the report of Dr. Bower as published in the *Monthly Bulletin* of the Philadelphia Department of Health. It is a survey of 5121 cases in 1928–1929 and 3095 in 1930. The proportion of deaths where laxatives were used is striking. Of 402 patients who gave a positive history of not having had a laxative, 5, or 1 of every 80 died; of 992 who received a laxative, 73, or 1 in 14 died; among the 992 cases, of 103 who received two or more laxatives (in several cases 4 laxatives), 15, or 1 in every 7 died.

"The following quotation is of special interest to you as taken from this same article: 'With the coöperation of the Philadelphia County Medical Society and the Philadelphia Association of Retail Druggists, an effort has been made to warn the public of the dangers of administrations of laxatives and the delay in operation in acute abdominal pain. The former supplied the sticker warning, and 300,000 were sent to all physicians in this city; the latter provided placards which were displayed in drug stores warning the public

against the use of laxatives in acute abdominal pain. Radio talks were also utilized for this purpose.' "

The difficulties arising in diagnosis in major abdominal emergencies are so great that it is unwise for any layman to make haphazard guesses. We often see accounts in newspapers of some unfortunate dying suddenly of "acute indigestion," a term about which we are very skeptical. Many of these are cases of coronary thrombosis (occlusion of the arteries that supply the heart muscle with blood) and have nothing to do with the gastrointestinal tract.

Dyspnoea is another important symptom and most easy to recognize. It means difficulty in breathing or in other words "shortness of breath." It is recognized by the increased frequency of the chest movements and the increased action of the essential and auxiliary muscles of respiration. If dyspnoea progresses there is added to it an anxious countenance, dilated pupils and finally cyanosis (blueness of the lips and face). Also frequently the patient breaks out in a cold sweat. The blueness is caused by deficient oxygenation of the blood and an increase of carbon dioxide. Only in its intense form does it become general. When slight, it appears in regions that have an abundant capillary circulation and translucent integument, such as the tip of the nose, the ears, the lips and mucous surface of the mouth, the face and especially the cheeks.

Cyanosis is always a serious omen. We also see it in derangements of the circulatory apparatus, as in diseases of the heart and arteries, and persistent foramen ovale. Certain drugs in overdoses may produce it, such as coal-tar derivatives, especially acetanilid, and nitrobenzole. In poisoning by illuminating gas the color is cherry-red, due to the presence in the blood of carbon monoxide hemoglobin.

Vomiting, another distressing symptom, is the forcible expulsion of the contents of the stomach through the mouth. In exceptional cases, as in intestinal obstruction, the contents of the intestines may also be expelled through the mouth—fecal vomiting.

The causes are numerous. Vomiting due to direct irritation of the terminal fibres of the vagus in the stomach is very common and occurs in abnormalities of the contents of the organ, gastritis, peptic ulcer, and in gastric cancer. When caused by central irritation of the vagus it is projectile in character and not preceded by nausea, and it is independent of food intake. Vomiting of gastric origin is followed by a sense of relief, while that of cerebral origin is not. In the latter type we must suspect diseases of the brain and its membranes—anemia, hyperanemia, concussion, sea-sickness, tumor, abscess, meningitis. Another type is the reflex form caused by local irritation of the throat, peritoneal irritation, visceral diseases, disorder of the female sex organs, pregnancy, and in certain nervous disorders. Many other causes could be enumerated, but those given are enough to show how varied the factors are and how important it is to determine their origin.

Among the emergencies that create the most anxiety are those that deal with derangements of consciousness, such as coma, shock and collapse. They indicate some sudden and grave calamity involving both the circulatory and nervous systems.

Coma, which is easily recognized, is often of obscure origin and occurs not only in cerebral disease but in the most varied constitutional conditions. It may be caused by organic disease of the brain, as in cerebral syphilis, acute ancephalitis; or focal, as in intracranial hemorrhage, embolism, thrombosis; in inflammation of the meningis; in traumatism of the head; in fully developed febrile infectious diseases. Only exceptionally is coma complete under these circumstances. Early and complete coma occurs in the severe forms. We find it in uremia, diabetes, acute yellow atrophy of the liver, narcotic poisoning, especially by morphine, chloral, poisonous gases; anesthetics as ether, chloroform and nitrous oxide; drowning and asphyxia from other causes; sunstroke and other conditions produced by excessive heat; hysteria.

Unconsciousness, for the benefit of the first-aider, can be placed under two main headings, the "red" and "white" types. In "red" unconsciousness there is an excess of blood in the head and the patient appears flushed. This immediately suggests the possibility of apoplexy, alcoholism, sunstroke, epilepsy and sometimes fractured skull. In "white" unconsciousness the face of the patient appears blanched and is found in fainting, nervous shock, heat exhaustion, freezing and extreme hemorrhage. This classification logically suggests treatment, namely, in the "red" form the head should be kept higher than the body and in the "white" form the head is kept lower.

The emergencies in which a pharmacist has exceptionally good training are those of acute poisoning. His knowledge of poisonous drugs and chemicals gives him an advantage over the layman. He is taught what antidotes and emetics to give. His responsibility ceases after the preliminary aid is given. The after-care of the patient must be assumed by the physician.

So far we have considered the duties of the first-aider. We have barely touched on diagnosis and very briefly and incompletely considered a few important symptoms. It would be desirable to speak of other symptoms but the time allotted will not permit. However, just a word about treatment in general as applied to emergency cases. *First,* be reasonably sure of your diagnosis. In the event that you are uncertain as to the nature of the trouble, do nothing. Keep the patient warm and comfortable until the arrival of the physician. *Secondly,* if the cause is determined, the following six rules should be your guide:

1. If the patient is not breathing artificial respiration should be administered at once
2. If external bleeding is apparent it must be controlled at once. Internal bleeding can only be handled by a physician
3. If signs of severe nervous shock are present it must be treated immediately preceding all other treatment except that indicated under artificial respiration and bleeding
4. If fractures are present extreme care must be taken in handling the patient to prevent complications. Improper handling may result in serious trouble
5. If injuries to the head or "red" unconsciousness are present care must be taken that no stimulants are given except as a last resort in case of the most severe nervous shock and weakness of the patient
6. In all cases except sunstroke immediate steps must be taken to keep the patient warm. This measure may mean the difference between life and death.

In conclusion a plea is made for a better understanding of the subject by the pharmacist. It is urged that the subject be taught in all schools of pharmacy.

The next speaker was Dr. J. J. Wittmer, Medical Director, New York Edison System Electric Companies, and Assistant Clinical Professor of Medicine, Long Island College of Medicine, who delivered an extemporaneous address on "Surgical Emergencies," illustrated by blackboard sketches and by reference to a skeleton and anatomical models. He spoke on eye injuries, earache, cuts with and without hemorrhages, simple and compound fractures, dislocations, internal hemorrhages, shock and burns and emphasized what the pharmacist should or should not attempt to do in the way of first aid for such cases.

The third speaker was Mr. S. M. Pratt, Safety Engineer, Brooklyn Edison Company, who spoke on "Artificial Respiration;" he referred in detail to those cases when artificial respiration is necessary and vital, such as gas poisoning, drowning and shock; he said that the pulmotor was becoming obsolete, inhalators of various types taking its place and being used in conjunction with artificial respiration. He stressed the fact that pharmacists should be capable of applying artificial respiration to accident victims brought into their pharmacies in a non-breathing condition, as any loss of time in such cases would probably result in death. Mr. Pratt, assisted by a corps of 5 men from the Brooklyn Edison Company, then demonstrated the "Schaefer Prone Pressure Method of Artificial Respiration" accompanied by the use of the H. H. Inhalator. Full directions for this method, as given by Mr. Pratt, follow:

"Artificial respiration must be applied whenever the patient is not breathing. It must not be applied when the patient is breathing.

"To determine whether the patient is breathing place your hand on the patient's chest just below the collar bone and again below the breast bone. If no movement is felt at either location, start artificial respiration immediately.

"The *Patient* must first be placed on his stomach. Grasp the forearms just above the wrists to prevent spraining the wrists. Place the arms vertically over the head and roll the body over by pulling one arm squarely across the body.

"Bend one arm at the elbow and place the patient's head so that the temple rests securely on the hand, with the face turned in the direction of the fingers.

"Extend the other arm as far forward as possible to extend the chest cavity to its maximum expansion.

"Pull the tongue forward and remove any foreign bodies which might interfere with breathing. Should the jaw be locked, make no further efforts to open the mouth.

"Kneel astride of the patient. Turn your palms out, using the edges of your hands on

the patient's back, run your hands down until they strike the hip bones.

"Cup your palms over the small of the back, the wrists facing each other about 4 inches apart, with the thumb and the first two fingers over the floating ribs.

"Swing forward, with the arms held stiff, until your shoulders are directly over the hands. Adjust your position to bring your thighs parallel with your arms.

"You are now ready to apply artificial respiration.

"Allowing one second to each count, at '1' place the hands and start swinging forward; at '2' the shoulders are vertical over the hands; at '3' remove the hands from the back and allow the arms to drop, relaxed. During '4,' '5' sit upon the heels and rest.

"The patient is thus made to breathe approximately 12 times per minute. Count as you proceed.

"When another man is available, the *Operator* may be relieved, but the patient may die if artificial respiration is interrupted during the exchange of operators. To avoid this a standard method of changing operators is necessary.

"The *Relief Operator* is coming on from the right side, so his right knee is placed against the *Operator's* right knee. *Operator* counts aloud, and *Relief Operator* counts with him, to get the proper rhythm.

"Using the *Patient's* body as a support, the *Operator* swings off the *Patient* at the count of '1,' and completes another cycle of respiration from his side while the *Relief Operator* moves his right knee into the position against the patient.

"The *Relief Operator* then completes a cycle of respiration from his side while the *Operator* moves away. At the next count of '1,' using the *Patient's* body as a support, the *Relief Operator* swings his left knee over the *Patient* and assumes the proper position.

"A matter of major importance is the avoidance of nervous shock due to the rapid cooling of the *Patient's* body.

"This heat loss is the most dangerous when the *Patient* is exposed to the elements.

"To combat this, the *Patient* must be thoroughly wrapped. For this purpose it is preferable to use a woolen blanket with a rubber blanket outside of it.

"Place the blanket, rolled to half its width, alongside the *Patient,* with the rolled part next to the body.

"Counting aloud, the *Operator* shifts to the offside and continues administering artificial respiration from that position. His sole interest is the regularity of the breathing.

"At the count of '3' the *Assistants* roll the body onto one side, unrolling the blanket half way under it. At '1' the *Operator* continues work. At '3' the *Assistants* roll the body in the other direction and complete unrolling the blanket. To assist in conserving the *Patient's* body heat, place hot pads between the legs at the crotch, under the armpits, near the heart, and up and down the torso. At the next count of '3' the *Assistants* bring the edges over the *Patient's* back.

"The *Operator* now shifts back into normal position.

"To keep the patient properly protected under extreme weather conditions, it may be necessary to move the patient to a sheltered location.

"Where this is necessary, three men kneel alongside the *Patient,* on the knee nearest the *Patient's* feet. Counting aloud the *Operator* shifts to the offside. The lifters place their arms under the *Patient.* The *Operator* applies pressure from this position.

"At '3' the *Lifters* raise the *Patient* to their knees. At '1,' the *Operator* clasps his hands around the *Patient* at the diaphragm, and constraining the abdomen, scissors fashion, causes an exhalation.

"At '3' the *Lifters* stand up. The *Operator* causes an exhalation at the count of '1.' This treatment is continued until the *Patient* has been carried to the sheltered location. The *Patient* is then lowered, first to the *Lifters'* knees, the *Operator* meanwhile continuing to administer artificial respiration as described, and then to the ground.

"The *Operator* then shifts back into normal position.

"The problem of the removal of noxious gases from the blood, and of supplying oxygen mixed with a breathing stimulant, carbon dioxide, is important.

"For this reason an inhalator, when it is available, should always be used in conjunction with artificial respiration.

"Never delay or interrupt artificial respiration because of the inhalator. The inhalator assists resuscitation but never replaces artificial respiration.

"One man is delegated to handle the inhalator. He fills the reservoir with carbogen, *i. e.,* 93% oxygen, 7% CO_2, and places the mask securely over the *Patient's* face.

"The flow of carbogen should be so adjusted that the bag fluctuates, being depressed by each inhalation and filled during each expiration.

"We will now assume that the *Patient* has been revived and is breathing of his own volition.

"Keep the *Patient* lying down. Do not permit any exertion for several hours. Watch for a possible relapse.

"Continue the application of the inhalator until the *Patient* is normal."

The meeting was now thrown open for discussion and Messrs. Christ, Gesoalde, Seley, the president and the secretary took part.

Dean Anderson moved a rising vote of thanks to the speakers and the corps of men who had taken part in the demonstration; this was carried with applause.

Dr. Fischelis again expressed the thanks of the New York Branch to the Kings County Pharmaceutical Society for the splendid program they had arranged. He then appointed a Nominating Committee consisting of Dr. Mayer, Prof. Canis and Dr. Schaefer to bring in a report on nominations for Officers of the Branch for 1932 at the next meeting.

Following the adjournment of the meeting, many of the members made a tour of the building.

HERBERT C. KASSNER, *Secretary.*

PHILADELPHIA.

NOVEMBER MEETING.

The November meeting of the Philadelphia Branch of the AMERICAN PHARMACEUTICAL ASSOCIATION was held at Temple University, School of Pharmacy, Tuesday evening, November 10, 1931, the meeting being called to order at 8:20 P.M.

President Munch introduced Dean John Minehart, of the School of Pharmacy, Temple University, who is celebrating his twenty-fifth year of association with the school. Dr. Minehart, responded by very generously recalling many pleasant reminiscences first of his induction to the deanship and second the splendid coöperation received during the ensuing years. He stressed the fundamental qualities both pharmacists and physicians should possess and the necessity for their closer coöperation. The official crude drugs came in for their share of praise, stressing the necessity for their proper handling.

The chief speaker of the evening, Mr. L. E. Warren, Chemist, Food and Drug Control, United States Department of Agriculture, was next introduced by the President. The subject of his talk—"Pharmacy and Medicine in Ancient Egypt." Many illustrations featuring actual photographs of original material found in Egypt were shown. The material thus illustrated consisted of various instruments; certain implements, copies of different papyri; weights and measures; mosaics with their interpretations and murals depicting various stages of operations on the human body.

A rising vote of appreciation was extended Mr. Warren.

DECEMBER MEETING.

The December meeting of the Philadelphia Branch, AMERICAN PHARMACEUTICAL ASSOCIATION was held in the Library of Sharp and Dohme, Manufacturing Chemists, at Broad and Wallace Streets, Philadelphia, Pennsylvania, on the evening of December 15, 1931. The meeting was called to order at 8:15 P.M.

The minutes of the November meeting were read and approved.

Under the new business, Chairman Slothower proposed the name of A. Homer Smith for Branch membership. On vote, Mr. Smith was accepted as a Branch member.

President Munch then announced the subject for discussion—"A Symposium on Digitalis." Various phases discussed were the Botany, Pharmacognosy, Manufacture of Galenicals, Bioassay and Standardization, Marketing and the Clinical Indications for this drug.

The first apeaker was E. H. MacLaughlin, who very aptly described the Botany of the plant, the significance of its common names and especially the growing habits of the official variety. Among his exhibits were leaves of the official drug; a decolorized leaf to show type of venation and samples of seeds from six different other varieties of non-official Digitalis plants. Of decided significance were the seeds of the official variety, since they were the smallest of the Digitalis varieties shown.

The Pharmacognosy of Digitalis was described by W. J. Stoneback, who showed how the drug may be identified both macroscopically and microscopically. The chief points of interest during this phase of the discussion were the histological location of the glucosides, and the reagents used to demonstrate their presence. The leaves of *Digitalis purpurea*, *Digitalis ambigua* and *Digitalis lanata* were compared for macroscopic appearance. Types of trichomes, their placement of the leaves; their length and width in microns furnish the

microscopic differentiation of the three species compared.

The "Manufacture of Galenicals" was carefully described by L. L. Miller. His description started with the grinding of the drug; its extraction under carefully regulated conditions; its standardization before packaging and finally the description of the finished product ready for the market.

The U. S. P. assay method for Digitalis and its preparations was discussed and illustrated by P. S. Pittinger. The apparatus and animals required together with the standard substance (ouabain) for the comparison and adjustment of final results were explained in detail.

Ambrose Hunsberger acquainted the audience with the number and variety of Digitalis and its preparations a dispensing pharmacist is required to handle. He emphasized the necessity of proper storage to prevent rapid deterioration and commented on the difference in keeping qualities possessed by preparations made twenty years ago with those of recent manufacture.

The climax of the meeting came when Dr. J. E. Wolffe gave the impression of various clinicians; how some do prescribe and how others should prescribe digitalis preparations according to indications shown by various heart conditions; and the results they expect to get when preparations of this type are prescribed.

On motion a rising vote of appreciation was extended to the speakers of the evening.

After the meeting a tour was made through the Crude Drug Mill and the other departments of the plant where Digitalis preparations are manufactured; the thought being to start with the crude drug and to follow through to the finished product.

In this the Committee on Arrangements was successful, as many favorable comments were made.

An audience of seventy-five was in attendance.

The officers of the Branch wish to take this opportunity of thanking Sharp and Dohme for their coöperation and courtesy in helping to make this meeting a successful one.

W. J. STONEBACK, *Secretary.*

ACADEMY OF PHARMACY AND NORTHERN OHIO BRANCH.

The following is a report of the first meeting (January 12th) of the Academy of Pharmacy and the Northern Ohio Branch of the AMERICAN PHARMACEUTICAL ASSOCIATION.

The society held its first regular meeting of 1932, Friday, January 8th, at the lecture hall of the School of Pharmacy, Western Reserve University.

The meeting was preceded by the usual dinner and Council meeting held at the Faculty Club. Dean Jordan of Purdue University was guest of Council.

The following officers were installed for the coming year:

President, A. L. Flandermeyer
Vice-President, Emil Petersilge
Secretary, F. J. Bacon
Treasurer, Herbert Decker.

President Flandermeyer, Purdue 1900, introduced Professor Charles B. Jordan, Dean of the School of Pharmacy of Purdue University to the society. Dean Jordan presented a paper on "Some Aspects of Professional Pharmacy." (It is hoped to publish the address in a succeeding issue of the JOURNAL.)

After discussion the Academy voted its thanks to Dean Jordan for the interesting and instructive paper.

F. J. BACON, *Secretary.*

SOUTH DAKOTA STATE COLLEGE STUDENT BRANCH.

A meeting of South Dakota State College Student Branch was held by the Student Branch at South Dakota State College on December 9th.

The election of officers for the coming year was held. R. Matson, of Brookings, succeeded F. O'Connell, Boone, Ia., as *President;* M. Jelinek, of Canton, S. D., replaced W. Eer Nisse, of Hot Springs, S. D., as *Vice-President;* R. Gruetzmacher, of Gibbon, Minn., succeeded E. Pelant, of Minneapolis, as *Secretary,* and R. Fischer, Springfield, Minn., was elected *Treasurer,* all of the incoming officers being sophomores.

Dean Serles closed the meeting with a short address commending the society's first year of existence.

EDWARD A. PELANT, *Secretary.*

PITTSBURGH.

At the January meeting, Pittsburgh Branch, AMERICAN PHARMACEUTICAL ASSOCIATION, there was a Round Table discussion led by Frank S. McGinnis on the subject "Some Problems in Hospital Pharmacy." The annual election and instalment of officers was held.