The American Gynecological Society

PROGRAM

DIAMOND JUBILEE MEETING

May 7th, 8th, and 9th

1951

THE WALDORF-ASTORIA

New York City

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DIAMOND JUBILEE

SEVENTY-FIFTH ANNIVERSARY MEETING

OF

The American Gynecological Society

The profession is cordially invited.

Please bring your Program with you.

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Otto Schwarz, M.D.
(deceased)

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Secretary

Norman F. Miller, M.D.

Other Members of the Council

Norris Vaux, M.D.
Emil Novak, M.D.
Ludwig Emge, M.D.
Joseph L. Baer, M.D.
John Parks, M.D.
George Gardner, M.D.

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Entertainment

COMMEMORATIVE EXERCISES

The Program Commemorating the 75th Anniversary of our Society will be held immediately following the banquet on Tuesday evening.

Tuesday, May 8th

Cocktail Party for ladies, Fellows and guests
at 7:00 p.m.

The annual dinner for Fellows of the Society,
their wives and guests will be held at
8:00 p.m.
The Sert Room

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First Day, Monday, May 7th

Morning Session at 9:30 O'clock

Roll Call

Reception of Guests

Address of Welcome
DR. W. BARCLAY PARSONS
President New York Academy of Medicine
New York City

Response to Address of Welcome
DR. KARL MARTZLOFF
Portland, Oregon

SCIENTIFIC SESSIONS

The time for reading papers is limited to 15 minutes and for opening discussion, 5 minutes.

1. Experience with the Rh Factor in 1000 Consecutive White Obstetrical Patients.

DR. E. L. KING, New Orleans

Abst.—This report details observations based on the private practice of the authors and their associates in the past 5 years. All these patients were tested by the same hematologist, who is particularly expert in this special field. Patients tested by other laboratories and those delivered elsewhere after being cared for by us during pregnancy are not included.

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Of the 177 Rh negative women the possibility of isoimmunization was present in 86. In 13, this was found to be of a severity sufficient to affect their infants in varying degrees. In 7 others, isoimmunization was also found, but the titer of antibodies was lower or they appeared only at the end of pregnancy and the babies were not affected; some of these babies were Rh negative.

Ten fetal deaths were definitely due to Rh sensitization, two others were probably due to this cause. Five other babies were affected, but survived; one of these (age 4 years) is mentally defective, the others are normal. Details of particularly interesting cases are presented.

Discussion opened by DR. NEWELL PHILPOTT, Montreal, Canada.

2. Studies of Blood Oxygen Saturation and Causes of Death in Premature Infants.

DR. E. STEWART TAYLOR, Denver, Colo. *(By Invitation).*

Abst.—This paper presents the results of oxygen determinations done upon the capillary blood of 50 prematurely born infants. In addition, an analysis is made of the causes of death among infants born prematurely at the Colorado General Hospital. Autopsy findings on infants are correlated with the obstetrical histories of the mothers.

Blood oxygen determinations were made at birth, one-half hour, and at one hour of life. The results indicate that the percentage of infants reaching 80 per cent oxygen saturation of the blood one hour after delivery varies directly with birth weight. The mortality among the infants with the lower saturations at 1 hour of life was unusually high.

Analysis of premature infant deaths revealed an anatomical cause for the mortality other than prematurity and atelectasis, in over 90 per cent of the autopsies. A majority of the fetal losses were associated with congenital abnormalities,

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erythroblastosis, intra-partum infections, or intracranial lacerations. Most of the remaining infants died from asphyxia as evidenced by their clinical courses and autopsy findings. Pathology of pregnancy, labor and delivery contributed to premature infant asphyxial deaths in a high proportion of cases.

Discussion opened by DR. L. M. RANDALL, Rochester, Minn.

3. Pagets Diseases of the Vulva.

DR. CARL P. HUBER, Indianapolis, Indiana

Abst.—Extramammary Paget's disease is rare. It occurs on or near the external genitalia and in the axillae. These are the areas in which apocrine sweat glands are found. Paget's disease of the vulva presents an interesting pathological picture. The lesions are sharply defined, inflammed, edematous and indurated. An eczematoid weaping surface is produced which causes itching, tingling, burning and pain.

Microscopically the large, oval or round, swollen vacuolated "Paget" cells present a unique appearance lying between non-neoplastic epidermal cells, spreading centrifugally in the basal layers in the earlier stages and travelling upward as the epidermis becomes more involved. In areas, "Paget" cell masses in involved sweat glands are seen in direct continuity with "Paget" cells invading the epidermis.

The characteristics of apocrine glands and the differential diagnosis of Paget's disease are discussed. The microscopic appearance of three vulvar lesions of this type is demonstrated.

Discussion opened by DR. EMIL NOVAK, Baltimore, Md.

4. Studies on the Anemias of Pregnancy.

DR. CURTIS LUND, *New Orleans, La. (By Invitation).*

Abst.—A survey of 4001 pregnant women at the Charity Hospital of New Orleans indicates that approximately 20 per cent are

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anemic when the usual standards are applied. About 5 per cent have initial hemoglobin levels below 8 grams.

The present report is based on data obtained from over 200 mothers. The data with most significance were obtained from detailed studies of anemic and normal patients treated and untreated throughout pregnancy. In addition to the usual blood survey there were studies of bone marrow, plasma volume, erythrocyte protoporphyrin and, when indicated, serum bilirubin, urinary and fecal urobilinogen.

The results indicate that hemodilution is a factor of great importance which must be considered not only in the diagnosis of anemia, but also in evaluation of therapeutic response.

Studies of the erythrocyte protoporphyrin in conjunction with standard blood counts indicate that iron deficiency is the major cause of anemia in this area. These studies have been done on normal controls with and without iron therapy as well as in anemic patients with and without therapy.

Discussion opened by DR. FRANK E. WHITACRE, Memphis, Tenn. *(By Invitation)*.

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Monday Evening Session at 8:00 O'clock

Address by Guest Speaker

MR. CHARLES READ
Director Institute of Obstetrics and Gynaecology,
University of London
Gynaecological Surgeon, Chelsea Hospital for Women,
Queen Charlotte Maternity Hospital and Hammersmith
Postgraduate Hospital, London

ENTEROCELE

6. A Bacteriologic and Clinical Study of Pyometra.

DR. FRANCIS BAYARD CARTER, Durham, N. C.

Abst.—This report is a continuation of a bacteriologic and clinical study of pyometra. The predisposing factors and clinical conditions which cause pyometra are discussed. Emphasis is given to the anaerobic organisms found in the uterus or in remnants of the uterus. The bacteria isolated, the mode of infection and the classification of the bacteria are considered. The incidence of pyometra is much higher than a review of the literature suggests. This study presents only those patients who had complete anaerobic and aerobic bacteriologic studies done and as a consequence does not represent the true incidence of pyometra. Proper therapy frequently must be based on the bacteriologic findings.

Discussion opened by DR. FRANKLIN L. PAYNE, Philadelphia, Pa.

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7. Clinical Considerations of Benign Ovarian Cystomas.

Dr. Clyde L. Randall, Buffalo, New York.
(By Invitation).

Abst.—No laparotomy involves simpler surgery than the removal of an uncomplicated ovarian cyst. However, the pathology of the ovary presents an unequaled variety of possibilities and the effects of oophorectomy are dependent upon knowledge and judgment rather than operative skill. The best management requires prompt recognition of the type of cystoma and familiarity with the potentialities of the particular neoplasm discovered.

Individualization of cases will always be the rule, but we should occasionally re-evaluate our criteria and consider answers to such questions as:

How often do benign ovarian cystomas occur bilaterally?

How often does the carefully preserved "other ovary" develop a cystoma requiring a second laparotomy?

Do the chances for overlooking a bilateral tumor justify bisecting the other ovary when its appearance suggests no involvement?

Is reoccurrence likely if apparently normal portions of a resected ovary are preserved?

If the lining of a cyst appears grossly papillary, whether its fluid content is serous or pseudomucinous, how often may it prove to be malignant, even though routine sectioning indicated a histologically benign tumor?

Teaching evident in texts and current literature have provided a basis for evaluating the trends apparent in a study of women followed after removal of benign ovarian cystomas.

Discussion opened by Dr. William Mengert, Dallas, Tex.

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8. The Malignancy of Special Ovarian Tumors.

DR. D. NELSON HENDERSON, Toronto, Canada
(By Invitation).

Abst.—The close histogenetic relationship of the granulosa cell tumor, arrhenoblastoma and dysgerminoma warrants grouping them together for clinical and pathological study. For this paper the clinical histories and pathologic material of 38 cases of granulosa cell tumor, 7 of dysgerminoma and 3 of arrhenoblastoma have been reviewed. A long follow-up record was available for the majority of the granulosa cell neoplasms and all of the others. This revealed a known recurrence rate of 25% for the granulosa cell group, 71% for the dysgerminomas and 33% for the arrhenoblastomas. The usual histologic criteria of malignancy proved an inaccurate guide for all tumors in estimating their clinical malignancy. Recurrences in 2 cases after 10 years point to the value of long "follow-up" records in assessing the malignancy of these neoplasms. The incidence of recurrence in the dysgerminoma group with all recurrences taking place within 5 years emphasized the malignant nature of these tumors. Two of the 3 cases of arrhenoblastoma occurred in sisters. Both tumors were of similar histologic type, yet one patient has survived 8 years while her sister died within a year. High voltage X-ray therapy proved ineffective in treating recurrences in the granulosa cell and dysgerminoma group of neoplasms. The majority of the granulosa cell tumors and the three arrhenoblastomas were associated with clinical symptoms or signs of disturbance of sex hormone production. In the dysgerminoma group, 2 patients presented evidence of incomplete sexual development while the remainder appeared sexually normal and three of these had borne full term children.

Discussion opened by DR. GEORGE GARDNER, Chicago, Ill.

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Second Day, Tuesday May 8th

Morning Session at 9:00 O'clock

9. Renal Osmotic Work of Normal Pregnancy as Measured by Freezing Point Depression.

DR. DUNCAN REID, Boston, Mass.

Abst.—The purpose of the study was to determine: (1) if the solute excretory load of the kidneys is altered during normal pregnancy, (2) if tubular osmotic work is increased during normal pregnancy and (3) if the molecular concentration of urine as measured by freezing point depression can be used as a test for tubular function.

PRINCIPLE: A measurement of the total output of substances by the kidneys can be calculated from the freezing point depression of urine. A solution that contains one gram mol, 1000 milliosmols, of substances has a freezing point depression of —1.86 degrees Centigrade. Dividing the freezing point depression of the urine solution by 1.86 gives solute concentration as milliosmols per milliliter. Multiplying milliosmolar concentration by urine volume is a measure of the amount of dissolved substances.

RESULTS: The total output of substances, solutes, in the urine remains unchanged during the last 120 days of pregnancy. If the late puerperium is compared with pregnancy, an increase in output of 100 milliosmols, 10 per cent, is noted to occur in pregnancy.

An increase in 24 hour osmolar concentration per milliliter of urine is noted during the period 80-40 days prior to delivery. The peak of osmolar urine concentration coincides with the time when the plasma is most dilute. No difference in osmolar concentration is noted when the periods 100 days and 20 days prior to labor are compared.

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An increase in tubular osmotic work occurs during pregnancy largely as the result of plasma dilution. However, in the 9-40 day period prior to labor both plasma dilution and the increased molecular concentration of the urine results in the greatest increment of tubular osmotic work. In the last 40 days, average tubular osmotic work gradually decreases.

In an effort to determine the kidneys maximum ability to concentrate solutes, a urine concentration test has been devised. Fluid both in food and liquid drink is restricted to 500 cc during a 36 hour period. Samples of urine collected after this period of fluid restriction in normal pregnancy revealed an average molecular concentration of 1.16 milliosmols per cc. Nonpregnant controls averaged 1.1 milliosmols per cc. A term pregnancy with severe hypertension and superimposed toxemia was never able, even after repeated attempts to concentrate above 0.8 millimols per cc.

The freezing point depression determination concentration test may be especially useful in toxemia and renal disease because the complicating albuminuria does not interfere with the accuracy of the method. This is not true of specific gravity determinations where the size of the albumin molecule causes misleading interpretations.

Discussion opened by DR. WM. DIECKMAN, Chicago, Ill.

10. Complete Cesarean Hysterectomy. A Logical Advance in Modern Obstetric Surgery.

DR. EDWARD DAVIS, Chicago, Ill.

Abst.—The increasing safety of abdominal delivery has been a major factor in the improvement of maternal and infant mortality. The incomplete removal of the uterus at cesarean section has increased in frequency. However, this procedure has all the undesirable sequelae of incomplete hysterectomy in the non-pregnant individual. The large cervical stump may cause discomfort, abnormal vaginal discharge,

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bleeding and rarely cancer. Complete cesarean hysterectomy is the logical procedure for the residual stump complications are eliminated. The technique can be mastered easily by experienced obstetricians. There is no increased morbidity nor mortality following this operation. Postoperative results are far better than in incomplete cesarean hysterectomy for a good functional state of the remaining pelvic structure results.

Our experience with 100 complete cesarean hysterectomies during the last 4 years including the indications, morbidity and complications is discussed. Although this group is rather small from which to draw conclusions, our uniformly good results point to this procedure as a logical advance in modern obstetric surgery.

Discussion opened by DR. KARL WILSON, Rochester, N. Y.

11. Radical Hysterectomy with Bilateral Pelvic Lymph Node Dissection. Five Year Results—100 Cases.

DR. JOE V. MEIGS, Boston

Abst.—One hundred patients with cancer of the cervix operated upon by radical surgery have been followed for at least 5 years. End results are given and complications discussed. The operative treatment of cervical cancer has been carried out with a very minimal mortality. The results of the surgical treatment in Stages I and II are extremely satisfactory. An evaluation of lymph node involvement is presented. Urinary difficulties have been encountered and cared for; fewer should be expected in future series. An appraisal has been made of the ureters and kidneys by intravenous pyelograms 5 years after operation. A place has been established for the surgical treatment of cervical cancer.

Discussion opened by DR. HERBERT SCHMITZ, Chicago, Ill.

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12. Effect of Radiation on Metastatic Lymph Node Involvement in Carcinoma of the Cervix.

DR. WILLIS E. BROWN, Little Rock, Arkansas
(By Invitation)

Abst.—Carcinomatous metastasis to the pelvic lymph nodes from cervical carcinoma is the chief cause of death from cancer of the cervix. Such metastases produce ureteral obstruction and/or erosion of large vessels with their fatal sequelae.

Clinical experience suggests that carcinoma in these lymph nodes is not affected by the usual forms of irradiation. The concept has been developed that such cancer cells are in some way immune by virtue of their position in the lymph node. However, calculations of the tissue roentgens delivered from the usual form of external and intracavitary radiation indicate that in very few instances is the total amount of radiation delivered to the lateral pelvic walls adequate to sterilize these lymph nodes.

It was believed that by individualization of therapy and the proper integration of x-ray and radium we could deliver a minimal cancer sterilizing dose of radiant energy to the lateral pelvic walls.

Patients entering the University of Arkansas Gynecology Clinic were selected for study and the diagnosis of carcinoma of the cervix was confirmed by biopsy and pelvic examination. After routine work up a skin clip was placed on the anterior cervical lip and by means of an anterior-posterior film the distance from the cervical canal to each lateral pelvic wall (ischial spine) was calculated. External measurements were obtained in the usual fashion and depth dose calculations were made according to standard tables of radiation penetration. The total internal and external radiation therapy was planned to deliver an estimated 5,000 to 6,000 tissue roentgens (x-ray roentgens plus 2/3 value gamma roentgens) to the lateral pelvic walls.

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A modified Ernst applicator was used for the intracavitary application of radium or cobalt. The bladder and rectum were filled with contrast media and the lateral margin of the cervix was identified with a skin clip. Anterior-posterior and lateral films of the pelvis were taken and the total and specific distribution of radiant energy from each of the various foci was calculated. This prevented exceeding tissue tolerance in the region of the bladder, ureters, and rectum, and assured adequate concentration to the cervix and lateral pelvic wall.

At varying time intervals following the radiation, these patients were operated on and a lymphadenectomy, hypogastric artery ligation, and sympathectomy were done. Additional surgery was carried out when feasible and included variations of the Wertheim and pelvic evisceration procedure.

The results of these studies will be reported. Preliminary observations suggest that carcinoma in the lymph nodes can be destroyed by this form of planned radiation therapy. To date serious sequelae of such intensive radiation have not occurred. Our experience with the use of cobalt will be commented on. The effect of this form of radiation on five year survival cannot be determined at this time.

Discussion opened by Dr. R. Gordon Douglas, New York

13. Thrombosis and Embolism in Gynecologic Surgery.

Dr. J. P. Pratt, Detroit, Michigan

Abst.—Stagnation of blood, injury to blood vessels and infection are generally accepted as the basic causes of thrombosis and embolism. Control of each or any of these factors should lower the incidence of these vascular disturbances. The discovery of antibiotics has contributed to the better management of infections. Injury to the blood vessels is related to the judgment and technique of the surgeon. Early ambulation

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has been advocated to overcome stagnation of blood, but too little emphasis has been placed on prevention by pre-operative care. The problem begins before operation, continues through operation, and during post-operative period. The one fatal embolism in the last 10 years of surgery is reported. How the accident could have been prevented is considered.

Discussion opened by DR. LOUIS PHANEUF, Boston, Mass.

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PRESIDENTIAL ADDRESS

at 12:00 O'clock

DR. FREDERICK C. IRVING
Brookline, Mass.

Business meeting will be held Tuesday afternoon, time of meeting to be announced by the Chair.

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SEVENTY-FIFTH ANNIVERSARY PROGRAM

TUESDAY EVENING

May 8th, 1951

PROLOGUE

This was the program at the 1st AGS Meeting in 1876

Presiding Officer

DR. FORDYCE BARKER, New York

Etiology of Uterine Flexures with the Proper Mode of Treatment Indicated.

DR. THOMAS ADDIS EMMET, New York City

Discussion opened by DR. EDWARD R. PEASLEE, New York City.

Extirpation of the Functionally Active Ovaries for the Remedy of Otherwise Incurable Diseases.

DR. ROBERT BATTEY, Rome, Georgia

Discussion opened by DR. WILLIAM GOODELL, Philadelphia, Pa.

Labor Complicated by Uterine Fibroids and Placenta Previa.

DR. JAMES CHADWICK, Boston, Mass.

Discussion opened by DR. A. J. C. SKENE, Brooklyn, N. Y.

Latent Gonorrhea in Regard to its Influence on Fertility in Women.

DR. EMIL NOEGERRATH, New York City

Discussion opened by DR. J. MARION SIMS, New York City.

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Third Day, Wednesday, May 9th

Morning Session at 9:00 O'clock

14. Nutritional Deficiencies as a Causative Factor in Premature Labor and Toxemia.

DR. WINSLOW TOMPKINS, Philadelphia, Pa.
(By Invitation).

Abst.—The newer concept of the role of nutritional deficiencies in pregnancy establishes a relationship between the various conditioning factors which can be shown to increase the probabilities of premature labor and toxemia.

Alterations in chemistry, hematology, immediate pregravid weight and rate of gain in pregnancy significantly affect the incidence of premature labor and toxemia. Patients who commence pregnancy obviously underweight or overweight have an increased incidence of these catastrophes and those starting pregnancy at standard weight, but whose gain fails to follow the standard pattern, also have an increased incidence of catastrophe. These striking patterns have been developed:

First—increased maternal catastrophes occur among patients whose gain in weight is definitely in excess of average.

Second—an increased incidence of infant catastrophes occurs among patients whose weight is definitely below standard at the beginning of pregnancy or who fail to gain satisfactorily during pregnancy; if this pattern is also associated with excessively low hemaglobin values, there is an additional striking increase in the incidence of premature labor.

Third—when initial total Serum Protein and Albumin values were less than average, or Globulin values fail to

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increase satisfactorily, there is a marked increase in the incidence of toxemia.

Discussion opened by Dr. Willard M. Allen, St. Louis, Missouri.

15. Ovarian Pregnancy.

Dr. Leon Gerin-Lajoie, Montreal, Quebec
(By Invitation)

Abst.—The perfection of laboratory techniques and the better comprehension of the physiology of pregnancy have discarded as being Ovarian Pregnancy, such cases as did not conform to the accepted indispensabilities of implantation and the presence of ovarian tissues in the walls of the sac.

The rarity of the number of cases, and the similarity in some instances and the absence in other instances, of clinical symptoms of pregnancy, normal or ectopic, have rendered the preoperative diagnosis near impossible.

The evolution naturally differs according to the presence or the absence of a rupture and here again we are faced with a problem of no less complexity, in appraising the real value of the symptoms.

Even at the time of operation, it is difficult in the early pregnancies to certify that the imbedding of the sac was originally in the ovary and not in the fimbria.

Two cases are reported, one which is undoubtedly of primary ovarian origin, the other which the pathologist admits as such, but that our interpretation of the surgical findings does not conform to the accepted data.

The paper is illustrated by slides of gross and histological findings to favor discussion.

Discussion opened by Dr. Arthur Hertig, Boston, Mass.

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16. A Clinical and Surgical Review of Endometriosis.

Dr. Virgil Counseller, Rochester, Minn.

Abst.—This review covers the data on patients exhibiting evidence of endometriosis who were seen and regarded as having surgical problems during an 11 year period from 1938 to 1948 inclusive. Approximately 1,500 such patients were seen in this period. We have attempted on the basis of clinical findings and symptoms to determine beforehand which patients should be treated by conservative methods and which should be treated by more radical surgical procedures. Conservative surgical methods consist of excision, unilateral salpingectomy or salpingo-oophorectomy and presacral neurectomy.

The effects on the menses, the effects of previous surgical procedures, the effects on fertility, and the importance of associated uterine and adnexal disease with respect to the type of surgical treatment now to be considered were studied. The location of the lesions and the age of the patient definitely influence the type of treatment. The early use of conservative surgical measures seems to be advisable for many patients.

Restoration of fertility cannot be assured but may be improved. Normal menses and freedom from pelvic pain should be the purpose of the conservative surgical procedures. The types of lesions and their extent as determined by physical findings will usually indicate the necessity for radical surgery for relief of symptoms.

Discussion opened by Dr. Richard Le Linde, Baltimore, Maryland.

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FELLOWS

Adair, Fred L., *Life* .... Maitland, Florida
Aldridge, Albert .... New York, N.Y.
Allen, Edward D. .... Chicago, Ill.
Allen, Willard .... St. Louis, Missouri
Anspach, Brooke M., *Life* .... Philadelphia, Pa.
Bachman, Carl .... Philadelphia, Pa.
Baer, Joseph L., *Life* .... Chicago, Ill.
Bartholomew, Rudolph .... Atlanta, Ga.
Beck, Alfred, *Life* .... Brooklyn, N.Y.
Behney, Charles A. .... Los Alamos, New Mexico
Bill, Arthur .... Cleveland, Ohio
Brewer, John I. .... Chicago, Ill.
Brown, Thomas K. .... St. Louis, Mo.
Calkins, Leroy .... Kansas City, Kansas
Campbell, Alexander .... Grand Rapids, Mich.
Carter, Francis B. .... Durham, N.C.
Casler, DeWitt, *Life* .... Baltimore, Md.
Collins, Conrad .... New Orleans, La.
Cooke, Willard R. .... Galveston, Texas
Cosgrove, Samuel .... Jersey City, N.J.
Counseller, Virgil .... Rochester, Minn.
Crossen, Harry, *Life* .... St. Louis, Mo.
Cullen, Thomas, *Life* .... Baltimore, Md.
Curtis, Arthur H., *Life* .... Chicago, Ill.
Dannreuther, Walter .... New York, N.Y.
Davis, Carl H., *Life* .... Miami, Fla.
Davis, M. Edward .... Chicago, Ill.

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Dieckmann, William ....Chicago, Ill.
Douglas, Gordon ....New York, N.Y.
Duncan, James W. ....Montreal, Canada
Eastman, Nicholson J. ....Baltimore, Md.
Emge, Ludwig ....San Francisco, Calif.
Everett, Houston ....Baltimore, Md.
Falls, Frederick ....Chicago, Ill.
Farrar, Lilian, *Life* ....New York, N.Y.
Faulkner, Robert ....Cleveland, Ohio
Findlay, Palmer, *Life* ....Omaha, Neb
Fluhmann, C. Frederick ....San Francisco, Calif.
Fraser, John R., *Life* ....Almonte, Ontario, Canada
Gardner, George H. ....Chicago, Ill.
Goff, Byron ....New York, N.Y.
Goldsborough, Francis ....Buffalo, N.Y.
Harris, John W. ....Madison, Wis.
Healy, William, *Life* ....New York, N.Y.
Heaney, Noble S., *Life* ....Beverly Hills, Calif.
Henriksen, Erle ....Los Angeles, Calif.
Hertig, Arthur ....Boston, Mass.
Hesseltine, Henry C. ....Chicago, Ill.
Holmes, Rudolph, *Life* ....Charlottesville, Va.
Huber, Carl P. ....Indianapolis, Ind.
Hundley, John M., Jr. ....Baltimore, Md.
Hunner, Guy L., *Life* ....Baltimore, Md.
Hutchins, Henry, *Life* ....Boston, Mass.
Ingraham, Clarence, *Life* ....Denver, Colo.
Irving, Frederick, *Life* ....Brookline, Mass.
Kampermann, George ....Detroit, Mich.
Kimbrough, Robert A. ....Philadelphia, Pa.

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King, Edward L. ....New Orleans, La.
Kosmak, George W., *Life* ....New York, N.Y.
McCord, James R. ....Atlanta, Ga.
McKelvey, John L. ....Minneapolis, Minn.
Marchetti, Andrew ....Washington, D.C.
Martzloff, Karl ....Portland, Oregon
Masson, James C., *Life* ....Rochester, Minn.
Matthews, Harvey B., *Life* ....Brooklyn, N.Y.
Meigs, Joe V. ....Boston, Mass.
Melhado, Gerald C. ....Montreal, Canada
Mengert, William F. ....Dallas, Texas
Miller, James R. ....Hartford, Conn.
Miller, Norman F. ....Ann Arbor, Mich.
Moloy, Howard ....New York, N.Y.
Montgomery, John ....Philadelphia, Pa.
Montgomery, Thaddeus ....Philadelphia, Pa.
Moore, John ....Grand Forks, N.D.
Morley, William H., *Life* ....Orchard Lake, Mich.
Morton, Daniel G. ....San Francisco, Calif.
Mussey, Robert D. ....Rochester, Minn.
Nicholson, William R., *Life* ....Philadelphia, Pa.
Norris, Charles C., *Life* ....Bryn Mawr, Pa.
Novak, Emil, *Life* ....Baltimore, Md.
Payne, Franklin L. ....Philadelphia, Pa.
Peckham, Charles H. ....Cooperstown, N.Y.
Peightal, Thomas C. ....New York, N.Y.
Pemberton, Frank ....Boston, Mass.
Phaneuf, Louis ....Boston, Mass.
Philpott, Newell ....Montreal, Canada
Plass, Everett D. ....Iowa City, Iowa

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Pratt, Jean P. ....Detroit, Mich.
Randall, Lawrence ....Rochester, Minn.
Reid, Duncan ....Boston, Mass.
Reis, Ralph ....Chicago, Ill.
Richardson, Edward H., *Life* ....Baltimore, Md.
Rock, John ....Brookline, Mass.
Ross, Robert A. ....Durham, N.C.
Royston, Grandison D. ....St. Louis, Mo.
Rubin, Isidor C., *Life* ....New York, N.Y.
Rucker, M. Pierce, *Life* ....Richmond, Va.
Rushmore, Stephen ....Boston, Mass.
Scheffey, Lewis C. ....Philadelphia, Pa.
Schumann, Edward A., *Life* ....Philadelphia, Pa.
Scott, William A., *Life* ....Toronto, Canada
Smith, George V. ....Brookline, Mass.
Studdiford, William E. ....New York, N.Y.
Taylor, Howard C., Jr. ....New York, N.Y.
TeLinde, Richard W. ....Baltimore, Md.
Thoms, Herbert ....New Haven, Conn.
Titus, Paul ....Pittsburgh, Pa.
Traut, Herbert ....San Francisco, Calif.
Vaux, Norris W., *Life* ....Philadelphia, Pa.
Ware, Harry Hudnall, Jr. ....Richmond, Va.
Watson, Benjamin, *Life* ....New York, N.Y.
Wharton, Lawrence ....Baltimore, Md.
Williams, Phillip F. ....Philadelphia, Pa.
Wilson, Karl, *Life* ....Rochester, N.Y.

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HONORARY FELLOWS—AMERICAN

George W. Corner ....Baltimore, Md.
Eugene M. K. Geiling ....Chicago, Ill.

HONORARY FELLOWS—FOREIGN

Victor Bonney ....London, England
Eardley, Holland ....London, England
J. Munro Kerr ....Glasgow, Scotland
William Fletcher Shaw ....Manchester, England
Bernhard Zondek ....Jerusalem, Palestine

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In Memorium

ROBERT L. DICKINSON

Elected 1892 Died November 29, 1950

OTTO H. SCHWARZ

Elected 1927 Died August 19, 1950

GEORGE GRAY WARD

Elected 1909 Died December 20, 1950

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